West Area Diabetes Report 2024

In 2023/24 The Hangleton and Knoll Project (HKP) led a partnership funded by East Sussex Community Voice (ESCV) to deliver a range of community interventions, tailored to local communities.
Interventions were targeted at those at risk of or living with Type 2 diabetes looking to support positive lifestyle and self-care changes through empowerment of participants and to amplify the voices of patients in the services they receive. Work was targeted in Core20 areas with HKP working with West Hove PCN.

The aim of the project was to deliver –

- locally tailored programs that support self-management and promote preventative care. Sessions to include clinical and non-clinical discussions, information, and support. Information to be provided on NICE recommendations and ensuring all participants understand the eight care processes for diabetes.
- Supported signposting/referral and individual support for all participants to access a range of community offers that support resilience, confidence, physical exercise, wellbeing, digital access, and opportunities for volunteering.
- Peer support groups and follow-up offered as a sustainable progression for all participants.
- Diet education eg cookery course/workshops, including cooking on a budget.
- Bespoke offer for those with additional language needs and to ensure cultural appropriateness, including co-designing aspects of delivery with members of those communities.

This report contains a summary of the projects we co-designed and delivered with the community and primary care, outcomes for patients, clinical evaluation, system change and recommendations.

Contents –

Peer Support

We delivered and co-designed with the community a series of six Peer Support Group sessions, held bi-monthly in an accessible local community venue, to provide a whole community offer to residents in the West of the City.

We organised guest speakers to attend from a variety of services led by the needs of residents, we created and circulated posters to promote the sessions which were displayed in GP Surgeries, local shops, pharmacies, community buildings, and via social media. We also targeted invites via the community groups we support including 50+ groups, multi-cultural groups and groups running health focused activities including Yoga and Pilates.

In recognition of the prevalence of diabetes within local ethnically diverse communities, we focused on inviting and supporting people from those communities to attend the sessions, with targeted outreach via our Equalities and Inclusion Worker.

A total of 22 people attended Peer Support Group sessions. Attendance at each session varied between 9 and 18 people, with an average attendance of 13 people per session. As a result of our targeted outreach to members of ethnically diverse communities where diabetes is more prevalent, 70% of peer group attendees were from ethnically diverse communities.

Sessions delivered during 23/24

Theme	Date	Content
Healthy eating	June 2023	A guest speaker from Brighton and Hove Food Partnership provided a presentation and question and answer session about understanding different food groups and their impact on blood sugar. The attendees also shared tips with each other around healthy food choices, and talked openly about the challenges they face in maintaining a healthy lifestyle.
Diabetic Eye Screening	July 2023	The Manager of the Brighton and Sussex Diabetic Eye Screening Programme (DESP) gave a presentation about the importance of eyecare as a diabetic, the screening process, locations for screening and Saturday morning appointments in Brighton and Hove.
Blood Pressure (BP)	September 2023	Brighton and Hove Federation led a discussion around healthy eating in relation to Blood Pressure (BP) including increasing understanding around the link between diabetes and BP, sharing information on healthy lifestyles, and answering questions. Attendees were also offered the opportunity to have their blood pressure taken at the session.
Wellbeing	November 2023	Brighton and Hove Wellbeing service outlined its support offer for residents, including how to self-refer and access support from the service, and the impact that managing long-term health conditions can have on wellbeing. The group also learned about the importance of mental health and the effect that stress and anxiety can have on blood sugar and food choices.
Nutrition	February 2024	Presentation from Xyla representative about its NHS-approved low-calorie programme. In response to attendees' feedback that the presenter was very engaging, and their request for him to come back and host a talk about nutrition, the same presenter attended the session in March 2024.
Nutrition	March 2024	This topic was covered twice as it was the most popular amongst attendees; with many people feeling confused about information and advice they have received in the past around healthy eating. At the group's request, the session was hosted by the same Xyla representative as the February session.

Group Consultations

Between 1 April 2023 and 31 March 2024, we worked with Mile Oak Medical Centre (MOMC) to deliver two group consultations with patients living with, or at risk of, diabetes.

We researched and co-produced a best practice model for delivery of group consultations for Diabetic patients at MOMC in addition to a pre and post evaluation form to enable us to track change and form part of the final evaluation of the project, we developed this in partnership with Dr Tom Gelber, a GP from the practice.

The best practice model incorporated the National Institute for Health and Care Excellence (NICE) 9 recommended diabetes care processes.

Group Consultation – Cohort one

October/November 2023

The GP identified a cohort of patients who had received a recent (less than one year diabetes diagnosis)

45 patients were called by a member of HKP staff seconded to the surgery and were offered a place on the 7-week course, 18 people signed up to the course, 17 attended with an average of 14 per session.

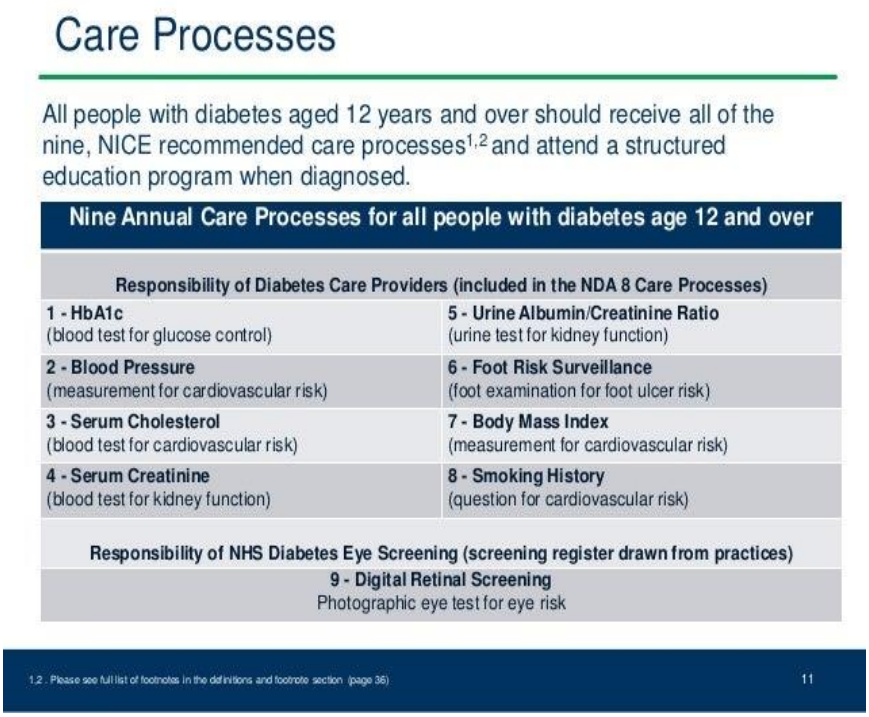
Each session was facilitated by two HKP staff and a GP/Nurse from the surgery, a healthy treat using recipes from the Diabetes UK website were provided at each session in addition to Diabetes UK recipe cards for patients to take home.

Each session was themed around the NICE care processes with HKP inviting relevant services to attend the sessions.

Group Consultation – Cohort two

In February 2024 the GP identified a second cohort of 31 patients who had received a diabetes diagnosis within the last 18 months/2 years. We used learning from the first cohort to plan the sessions and made the course slightly shorter, from 7 weeks to 5 weeks, whilst still incorporating all the NICE recommended care processes.

31 patients were contacted by HKP and 15 booked onto the course.



Care Processes

All people with diabetes aged 12 years and over should receive all of the nine, NICE recommended care processes[1,2] and attend a structured education program when diagnosed.

Nine Annual Care Processes for all people with diabetes age 12 and over	
Responsibility of Diabetes Care Providers (included in the NDA 8 Care Processes)	
1 - HbA1c (blood test for glucose control)	**5 - Urine Albumin/Creatinine Ratio** (urine test for kidney function)
2 - Blood Pressure (measurement for cardiovascular risk)	**6 - Foot Risk Surveillance** (foot examination for foot ulcer risk)
3 - Serum Cholesterol (blood test for cardiovascular risk)	**7 - Body Mass Index** (measurement for cardiovascular risk)
4 - Serum Creatinine (blood test for kidney function)	**8 - Smoking History** (question for cardiovascular risk)
Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices)	
9 - Digital Retinal Screening Photographic eye test for eye risk	

1,2 . Please see full list of footnotes in the definitions and footnote section (page 36) 11

Evaluation of Group Consultations

We partnered with the National Association of Primary Care (NAPC) who independently evaluated our group consultations using the data we collected from patients who completed the pre and post evaluation forms.

The NAPC evaluation concluded -

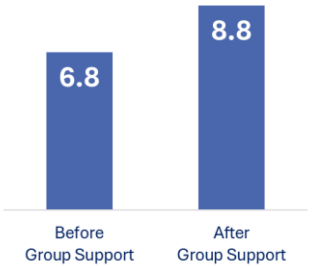
Community Group Consultations are associated with:

- A **30%** rise in patient **satisfaction** with the support they are receiving.
- **100%** of participants prepared to **recommend** group consultations to friends and family.
- A **38%** increase in the number of patients feeling that they have enough **time** to discuss their diabetes care.
- A **51%** rise in patient **understanding** about diabetes.
- A **39%** rise in patient **involvement** in decisions about their diabetes care.
- A **13%** rise in patient ability to take care of their own health from '**fairly able**' to '**very able**'
- **An estimated Return on investment of group consultations of 3.5 in NHS demand reduction alone.**

Key Details

- Took place in two cohorts in Oct 23 and Feb 24 across an average of **6** structured weekly sessions.
- Designed to provide tailored education and support for people with diabetes.
- Aiming to enhance self-management skills and knowledge.
- **76** patients invited to take part.
- **33** participants participated (a high 43% conversion rate that indicates that the chosen patients, engagement approach and intervention offer are appropriate).
- The average age of patients was **62**.
- **84%** were female.
- **11%** were from ethnic minority backgrounds.
- A WhatsApp group was created for continued support.
- Participants shared personal successes and tips.

Impact of Group Consultations on Care Satisfaction



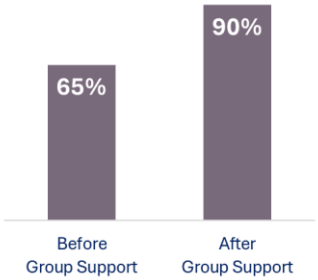
Patients saw a **30%** rise in their satisfaction with the support they are receiving – from 6.8 out of 10 to 8.8 out of 10.

100% of participants would recommend group consultations to friends and family.

How satisfied are you with the current support you receive to manage your diabetes?

1 (Not satisfied) to 10 (very satisfied)

Impact of Group Consultations on Time for Care

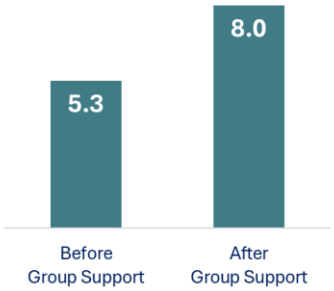


There was a **38%** increase in the number of patients feeling that they have enough time to discuss their diabetes care – from 65% to 90%.

% of patients answering yes to

Do you feel that you currently have enough time with your surgery to discuss your diabetes care?

Impact of Group Consultations on Understanding of Diabetes



Patients saw a **51%** rise in their understanding about diabetes – from 5.3 out of 10 to 8 out of 10.

How much do you feel you currently understand about diabetes?

1 (Nothing at all) to 10 (Everything)

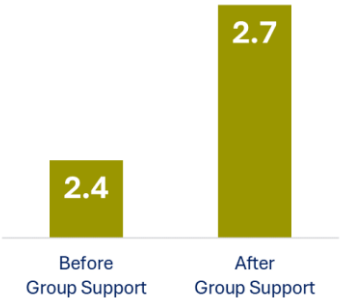
Impact of Group Consultations on Involvement in Care

Patients saw a **39%** rise in their involvement in decisions about their diabetes care – from 6.1 out of 10 to 8.5 out of 10.

How involved do you currently feel about the decisions made in your diabetes care?

1 (I don't feel involved) to 10 (I feel very involved)

Impact of Group Consultations on Patient Activation



Patients saw a **13%** rise in their ability to take care of their own health from '**fairly able**' (2.4) to '**very able**' (2.7) This rise is correlated to NHS Primary and Secondary Care demand savings of **£98** per patient per year

The cost of group consultations is approximately £28 per patient. This suggests a return on investment **(ROI) of group consultations of 3.5** in NHS demand reduction alone.

How good are you at taking care of yourself and staying healthy?

1. Not very | 2. Fairly | 3. Very | 4. Extremely

This ROI does not count the cost of any onward referral but nor does it count the benefit in year two, the benefit across other providers and the benefit of better health and wellbeing to patients and their families.

Impact of Group Consultations on clinical outcomes after 12 months

73% patients reduced their HbA1c, with an average fall of 7.45 mmol/mol.

61% patients reduced their BMI, with an average fall of 1.29 kg/m2

Case Study: Diabetes Group Consultation at Mile Oak Medical Centre
Cohort two 19th Feb 2024 – 18th March 2024

Basic Profile Data

Age: 72
Gender - Female
Ethnicity - White British
Sexual Orientation - Heterosexual
Disabilities - None

Background

Geraldine's life changed in January 2016 when her husband was diagnosed with Type 2 Diabetes. During routine tests around the same time, she discovered she was pre-diabetic, with a HbA1c blood test result of 47, bordering on the diabetic range. Motivated by their diagnoses, both Geraldine and her husband embarked on a journey to change and adapt their lifestyles. They cut down on carbs and sugary foods and began regular exercise, including daily walks. Her husband's medication, combined with their lifestyle changes, effectively managed his blood sugar, while Geraldine's annual blood tests consistently showed stable results within the pre-diabetic range.

Starting Point: Initial Presentation

In 2023, Geraldine faced another life-changing event: her husband was diagnosed with terminal cancer and passed away in November. The emotional toll was great, and spending most of her time in the hospital, she could not maintain her regular exercise routine or follow her usual diet. The stress, anxiety, and grief she experienced caused her blood sugar to spike and her HbA1c blood test results were at 50 in November and 51 in December.

This meant that by December 2023, Geraldine had been diagnosed with Type 2 Diabetes. Shortly after this, the Hangleton and Knoll Project's (HKP) community development worker reached out to her, inviting her to a series of diabetes group consults at Mile Oak Medical Centre. Despite some work schedule conflicts, Geraldine was eager to participate.

Participation in the Project

Geraldine attended three out of five group consults at Mile Oak Medical Centre, where she delved into various aspects of managing Type 2 Diabetes. The nutrition session was particularly enlightening. She gathered invaluable self-care tips, such as the importance of moisturising her feet to prevent dry skin and potential injuries that could be problematic due to her condition.

HKP further supported her by inviting her to a Diabetes Peer Support session with nutritionist James Belbin at St. Richard's Community Centre. This session was a revelation.

Geraldine learned that while fruit smoothies and shakes seemed healthy, their concentrated fruit sugar was detrimental to blood sugar control. She embraced new dietary habits, such as combining fruit with yogurt and seeds, and shifted her main meal to lunchtime. She also understood the critical role of exercise in managing Type 2 Diabetes.

Outcomes

The diabetes group consults at Mile Oak Medical Centre came along at the right time for Geraldine. Still trying to cope with her husband's loss, her blood sugar was climbing. The diabetes sessions gave her motivation to refine her diet and resume regular exercise.

HKP's community development worker recommended some low-cost drop-in exercise classes at St Richards Community Centre which Geraldine now attends weekly. One is focused on weight-based exercises and the other on yoga and relaxation. Additionally, she maintains a routine of walking 6,000 steps daily.

Her dedication has paid off. Her most recent HbA1c blood test showed her blood glucose level had dropped to 48. Though she had hoped for a lower reading, she remains determined to return to the pre-diabetic range and to avoid taking medication.

Geraldine found the diabetes sessions beneficial and despite a busy life filled with work, grandchildren, and friends, she values the weekly social interactions with a friendly group of participants at the exercise classes.

These diabetes sessions have provided her with the tools and community support to navigate her journey with Type 2 Diabetes effectively.

System Change

Alongside the group consultations and peer support sessions we worked with a small group of residents and the Diabetic eye screening (DES) manager for Sussex to identify barriers to patients attending their annual diabetic eye screening appointment as take up in Sussex is lower than average compared to other parts of the country.

The key barriers identified were –

- No direct bus route from Hangleton and Knoll to Goodward Court in Hove
- Lack of knowledge about alternative venues for screening including the Sussex County Hospital
- No knowledge of weekend appointments
- Taking time off work to attend (dilation eye drops mean vision is impaired for a few hours after the screening)
- Lack of understanding of the importance of eyecare for diabetics
- Childcare

As a result of barriers identified the following changes were administered across Sussex.

As a result of working with the Hangleton and Knoll Project to identify barriers people face in attending Diabetic eye screening appointments we have now included a list of all venues for screening and information on Saturday appointments with every eye screening invitation letter sent to c50,000 patients across Brighton, Hove and wider Sussex".

Buki Asanbe
Brighton and Sussex DES Programme Manager
NHS

Conclusion

The project was a significant success in developing and delivering a community response to Diabetes as a partnership between HKP, our communities, and primary care.

"I had a vision to bring group education and consultation to our practice to deliver high quality and forward-thinking diabetes care, and HKP helped me to do that. It would have been an almost insurmountable task without their help! Their staff took point in designing an education program with my clinical oversight and contacting outside speakers to talk on a variety of subjects relevant to self-management of diabetes, as well as contacting the patients themselves. Working alongside them has helped the project to run smoothly and I know from talking to patients who attended how well they have gone, and how much more they feel able to manage their own disease."

Dr Tom Gelber - Mile Oak Medical Centre

HKP's trusted relationships in the community enabled the hardest to reach residents to engage and participate in a variety of interventions and activities which improved their confidence and knowledge to better self-manage their Diabetes.

Our case study demonstrates the impact of the role Community Development Work plays in improving health outcomes for patients, signposting and supporting patients into community activities to support their health and well-being reducing the demand for clinical intervention.

HKP will continue to explore opportunities to partner with primary care in the West of the city to replicate this innovative model of partnership working with other GP practices.

Report Written by

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For and on behalf of The Hangleton and Knoll Project

July 2024

With special thanks to

Dr Tom Gelber GP Mile Oak Medical Centre

Jag Mundra National Association of Primary Care (NAPC)