Preventing Diabetes Together

Walthamstow West PCN · Programme Outcomes Report 2025–2026

Working-Age Adults

Reaching those most at risk before diagnosis

Reducing Inequalities

Making prevention genuinely accessible to all

Community-Led Care

Preventative care embedded in the local community

Project Overview

This programme placed communities at the heart of diabetes prevention — co-designed with **Blossom CIC** and delivered across five workshops between **November 2025 and February 2026.** The approach was deliberately inclusive, prioritising working-age adults living with prediabetes who face the greatest barriers to accessing traditional NHS services.

Community-Led

Co-designed and delivered with Blossom CIC to ensure cultural relevance and trust

5 Workshops

Delivered Nov 2025 – Feb 2026 across accessible community venues

Health Equity Focus

Reducing inequalities and improving access to preventative care for underserved groups

Prediabetes Target

Working-age adults identified through clinical data as being at risk of developing Type 2 diabetes

SMART Objectives

From the outset, the programme was structured around clear, measurable goals to ensure accountability and enable meaningful evaluation at every stage of delivery.

Workshop Delivery

5 workshops · 10–15 patients per session · structured preventative education

Point-of-Care Testing

Blood glucose & cholesterol checks on the day · immediate clinical follow-up where needed

Smoking Cessation

Targeted advice · warm referrals to local stop smoking services

Patient Confidence

Measurably increase knowledge and confidence in managing health and preventing diabetes

Digital Inclusion

Improve NHS App uptake · address digital exclusion among participants

Engagement and Reach

A rigorous outreach process was undertaken, starting with systematic identification through clinical records and moving through to supported bookings. The funnel below illustrates the journey from data to attendance — demonstrating both the scale of need and the dedication of the team to convert awareness into action.

374 Patients Identified

Identified via EMIS searches as living with prediabetes or elevated risk

275 Patients Contacted

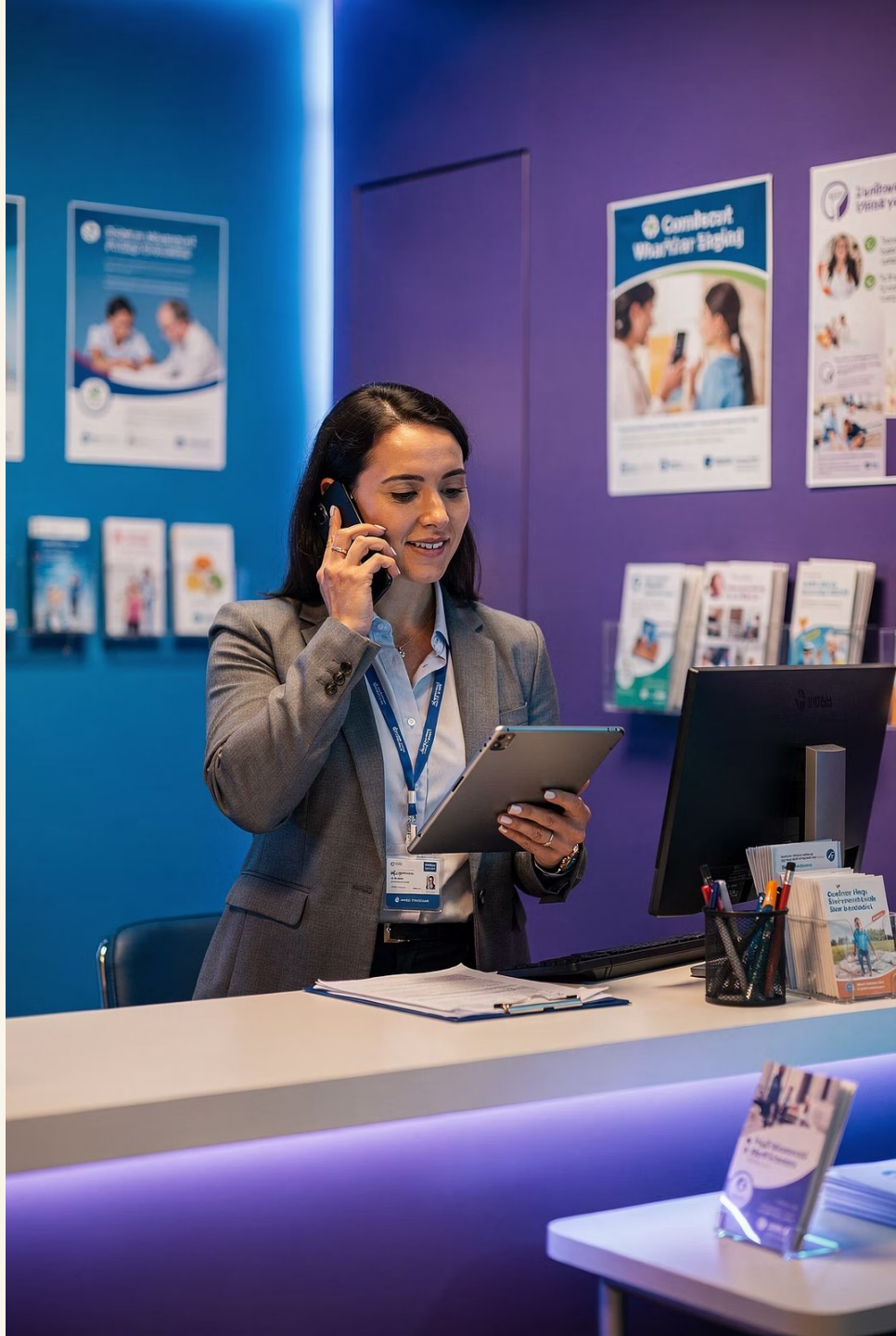
Reached by social prescribers through phone, text, and community outreach

159 Patients Booked

Successfully booked onto one of the five workshop sessions

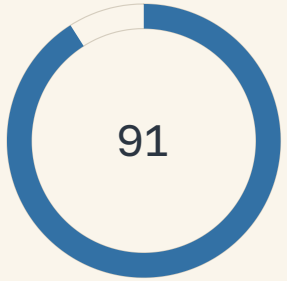
62 Attended Sessions

Participants who attended, including many from digitally excluded and diverse communities



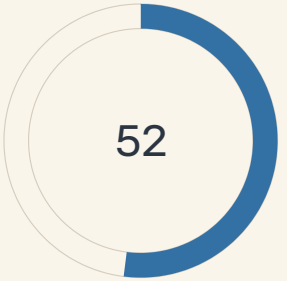
Programme Delivery

The integrated **'one-stop' model** was central to the programme's success — enabling participants to access clinical screening, personalised lifestyle advice, digital support, and community services all within a single session. This removed the burden of multiple appointments and made it easier for busy working-age adults to engage.



Health Checks

Completed across all 5 sessions

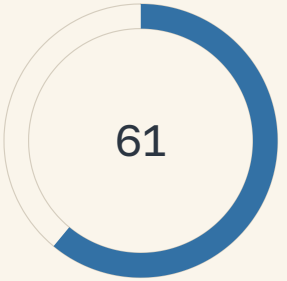


Blood Glucose

Point-of-care glucose checks carried out

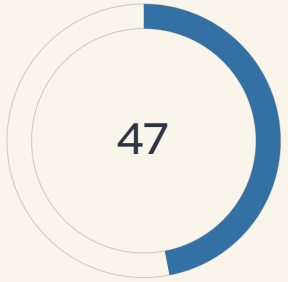
Cholesterol Tests

Immediate results and clinical follow-up provided



Dietitian Sessions

Personalised dietary and lifestyle guidance delivered



NHS App Setups

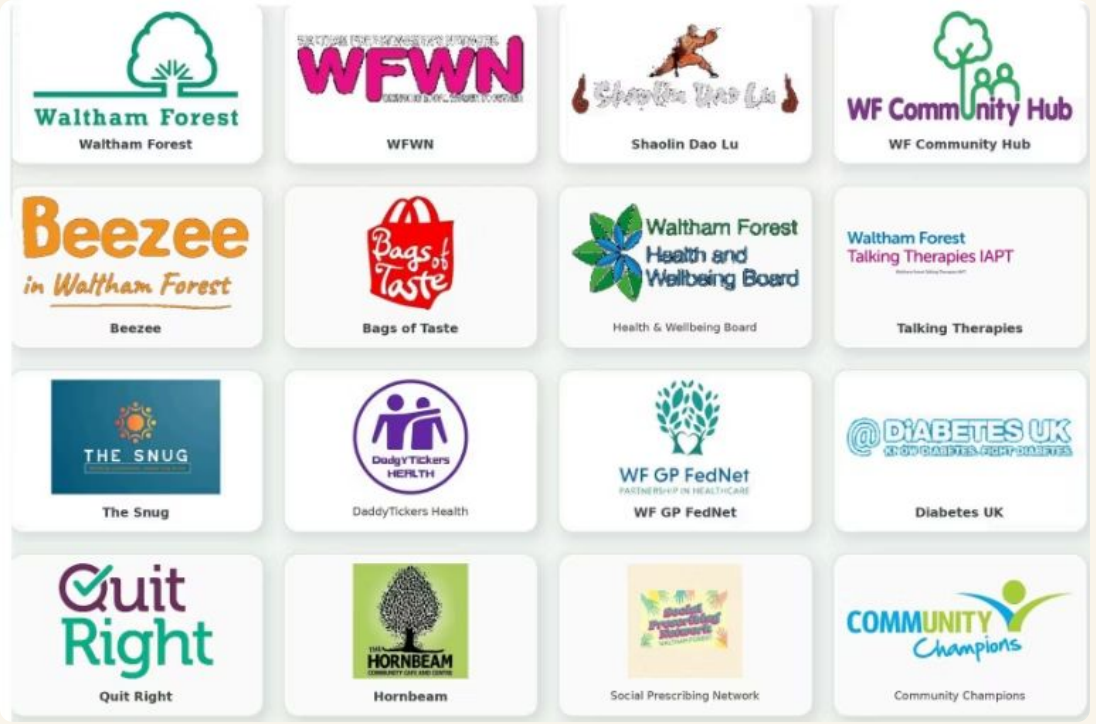
Participants supported to register and navigate the NHS App

Partnership Working

The programme's strength lay in its breadth of collaboration. Over **20 community and voluntary sector organisations** contributed to delivery, bringing culturally adapted support, multilingual volunteers, and expertise across health and social care. Holding sessions in trusted community venues — rather than clinical settings — significantly improved accessibility and reduced the stigma often associated with NHS services.

What Partners Brought

- Multilingual volunteers and culturally adapted resources
- Mental health and wellbeing signposting
- Housing, social isolation, and lifestyle support
- Trusted community relationships built over years



More than a programme.

A community movement.

By embedding prevention within trusted community spaces and co-designing every element with local people, this project demonstrated that health equity is achievable when the system meets people where they are.

20+

Partner Organisations

Community and voluntary sector groups contributing to delivery

62

Lives Reached

Participants who attended across five community workshops

5

Workshops Delivered

Nov 2025 – Feb 2026, across accessible community venues

Positives & Challenges

✅ What Worked Well

Trusted Community Settings

Workshops in familiar venues created a relaxed, accessible environment that generated strong engagement

Holistic Support

Significant interest in mental health, housing, and social isolation confirmed the importance of addressing wider determinants of health

One-Stop Model

The integrated approach enabled clinical, lifestyle, digital, and community support all within a single session

Multilingual Accessibility

Multilingual volunteers and culturally adapted materials strengthened access for diverse communities

⚠️ Challenges Encountered

Hard-to-Reach Patients

Some patients were difficult to contact or unable to attend due to work commitments, caring responsibilities, or personal barriers

Multiple Contact Attempts

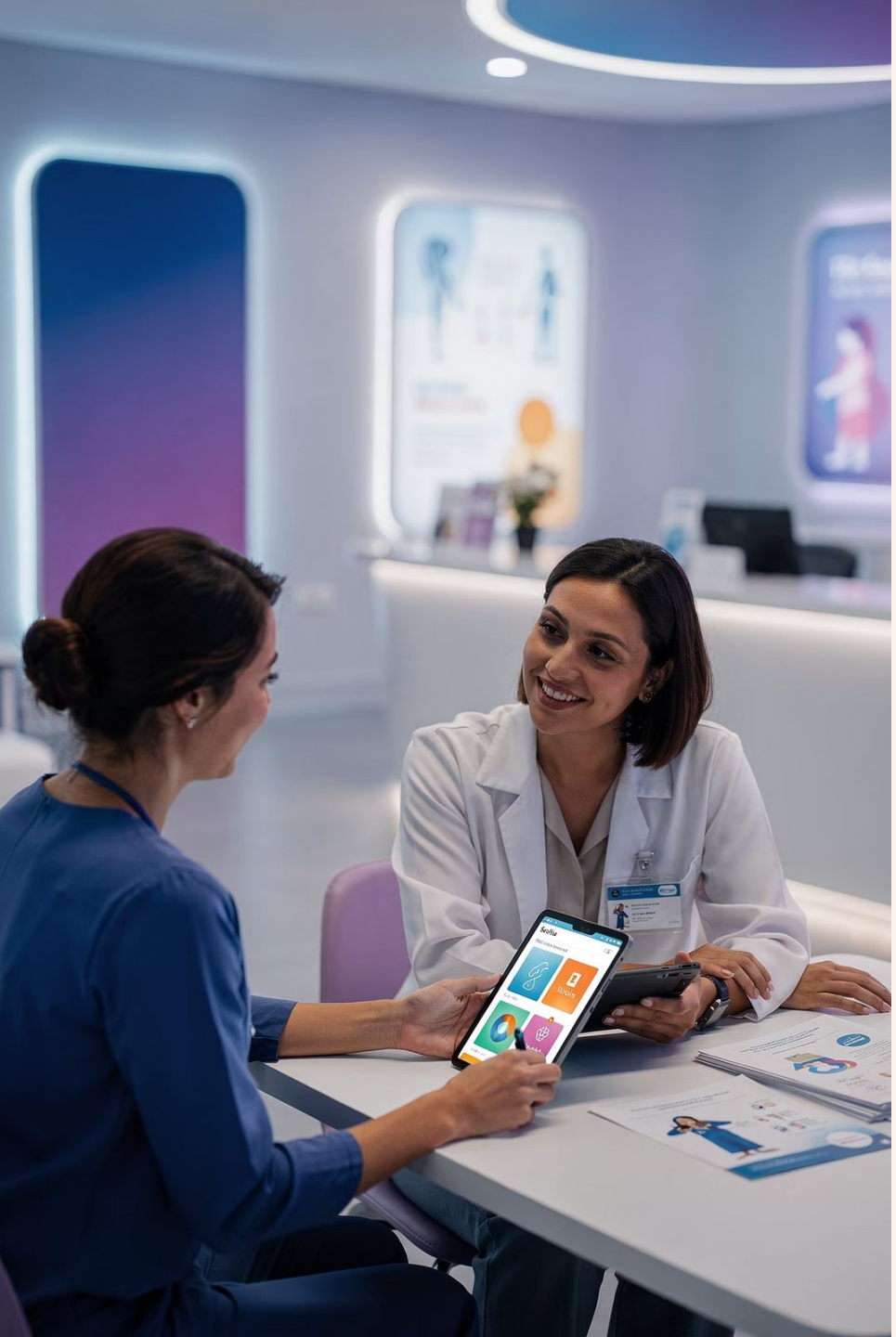
Reminder calls were routinely needed to secure attendance, particularly for working-age populations

Booking to Attendance Gap

Converting bookings to attendance remained an ongoing challenge across sessions

Evaluation Consistency

Collecting evaluation forms consistently was difficult; video feedback captured richer data but wasn't always feasible



Key Outcomes and Learning

The programme generated meaningful, measurable change — both in participants' knowledge and confidence, and in the way services can be delivered to reach underserved communities. These learnings will shape the next phase of the programme.

Improved Health Literacy

Participants reported a markedly improved understanding of prediabetes, risk factors, and practical steps to prevent progression to Type 2 diabetes

Increased Self-Confidence

Confidence in managing lifestyle choices — including diet, activity, and medication — increased significantly following participation

Community-Led Delivery Works

Engagement rates and participant satisfaction were notably higher when delivery was community-led rather than clinic-based

Holistic Need is High

Strong interest in support beyond diabetes prevention — including mental health, housing, and social connection — underscored the need for a whole-person approach

Proactive Outreach is Essential

Sustained engagement required consistent, proactive outreach and multiple reminder contacts to overcome everyday barriers to attendance

Future Development

Building on the strong foundation of this pilot, the programme is now ready to grow. The following priorities have been identified to deepen impact, broaden reach, and ensure long-term sustainability across Walthamstow and beyond.

Long-Term Follow-Up

Introduce structured outcome monitoring to track participant progress beyond the workshops

Expanded Outreach

Reach new audiences through workplaces, faith groups, and additional community venues

Health Champions

Develop a network of trained community health champions to sustain peer support

Obesity Prevention

Increase focus on obesity and earlier intervention for younger adults at risk

Scale Across PCNs

Replicate and expand the programme across additional Primary Care Networks in the borough

Video Feedback

> “Participants who were reluctant to complete written forms were often far more willing to share their experiences on camera.”

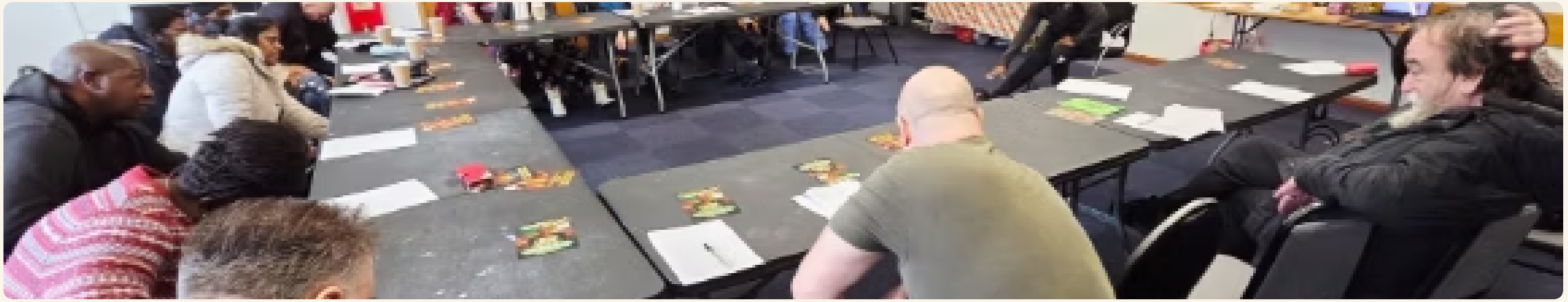
Participants shared their experiences in their own words. These short video testimonials provide a powerful and authentic account of the programme's impact — capturing stories that evaluation forms alone cannot fully convey. We encourage all partners and commissioners to watch the feedback to hear directly from those who attended.

🎥 Watch participant video testimonials here:
https://www.blossom-group.net/prediabetes-and-diabetes

This insight will inform how we capture outcomes in future phases.

Programme in Pictures

These images capture the warmth, energy, and diversity of the workshops — a community coming together to take charge of their health.

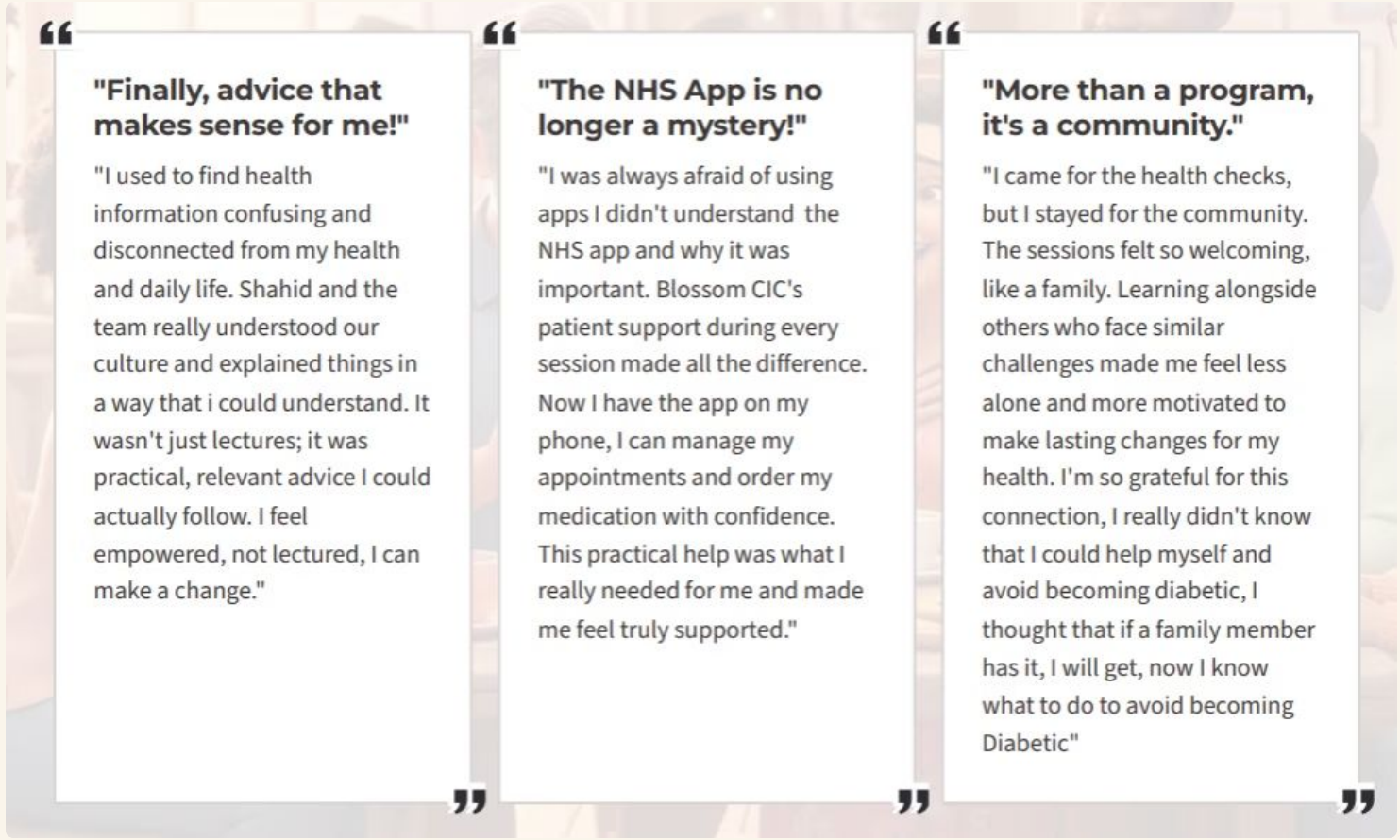


More Moments from the Sessions

From engaged group discussions to clinical checks and peer learning, these photographs reflect the breadth and quality of support delivered across the programme.

Patient Feedback

Participants described the programme as genuinely transformative — not just clinically, but in terms of confidence, community, and a renewed sense of agency over their own health. These are their words.



"Finally, advice that makes sense for me! It was practical, relevant advice I could actually follow. I feel empowered, not lectured."

"The NHS App is no longer a mystery. Now I can manage my appointments and order my medication with confidence."

"More than a programme — it's a community. Learning alongside others who face similar challenges made me feel less alone."

Partner & Volunteer Feedback

Partners and volunteers who contributed to the programme echoed the positive experience of participants — highlighting the collaborative spirit, the effectiveness of the community setting, and the tangible difference made to people's lives.

Partner and volunteer voices confirm that community-led delivery, when properly resourced and co-designed, can bridge the gap between NHS services and the communities who need them most.

Thank You

This programme would not have been possible without the commitment of Blossom CIC, our 20+ partner organisations, social prescribers, clinical staff, multilingual volunteers, and most importantly — the participants who gave their time and trust.

62

Participants

Working-age adults who attended across five workshops

20+

Partners

Community and voluntary sector organisations involved in delivery

91

Health Checks

Completed across all sessions

Questions?

We welcome your questions, reflections, and interest in scaling this work. Together, we can make diabetes prevention a reality for every community across North East London.

WALTHAMSTOW WEST PCN | BLOSSOM CIC | PREVENTING DIABETES TOGETHER