Beneficiary, living with pre-diabetes:

"Since I have been attending the live well hub, I have made many friends who help and support me on this journey. I have a much better understanding and realise how important it is to manage being pre diabetic. My HBA1C reading is coming down and generally I am happier and fitter than I have been in a long time"

Beneficiary living with pre-diabetes.

Engaging Diabetes Communities

Interim Evaluation Report

28th February 2023 - 31st August 2025

COMMUNITY FUND

September 2025

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DiABETES UK
KNOW DIABETES. FIGHT DIABETES.
NORTHERN IRELAND

LIVE WELL HUBS

LIVE Well

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1. Executive summary

1.1. Introduction

The purpose of this interim report is to evaluate the first 2.5 years (30 months) of Diabetes UK's 5-year project Engaging Diabetes Communities. The project delivered support to people living with and at risk of diabetes (including those living in type 2 diabetes remission) in Northern Ireland through the hybrid delivery of nine project activities.

1.2. Progress against project outputs, outcomes and KPIs

Table 1. Interim project progress against output targets, outcomes and KPIs	
Project Output Target	**Evaluation**
Awareness raising – three sessions per community	**Exceeding target**
Growing a community of volunteers – two Living Well Ambassadors (LWAs) per Live Well Hub	**Below target**
Live Well Hubs – two created per year	**Meeting target**
Wellbeing Programme – two delivered per year	**Meeting target**
Peer support groups – eight sessions delivered per year	**Exceeding target**
Project Outcomes	**Evaluation**
The project will support participants to increase their understanding of diabetes, enabling them to make healthier choices to improve their lives. This improved knowledge, together with the work of volunteers and LWAs in each area, will have a lasting improvement on community infrastructure.	**On track**
The support groups and befriending service will encourage ongoing friendships and connections which will greatly reduce feelings of isolation. This will also help to build and connect communities, empowering them to embed diabetes support.	**On track**
Increase knowledge and understanding around diabetes, equipping people with information to make better health choices	**On track**
Improve health and wellbeing, empowering people to live well with diabetes throughout the pandemic	**On track**
Empower communities to stay connected as we recover from COVID, supporting them to embed diabetes support into local infrastructure	**On track**
Project Outcomes	**Evaluation**
3,500+ interventions to people living with and at risk of diabetes	**Exceeded KPI**

1.3. Recommendations for the second half of the project:

1. Explore new ways to engage people aged 35-65.
2. Collect more data on the mechanisms of infrastructure change.
3. Enhance data collection around tackling inequalities.
4. Begin impact measurement with community partners.
5. Continue exploring ways to recruit and retain LWAs.

1.4. Conclusion: Engaging Diabetes Communities was successfully mobilised and is on track to exceed its KPI, achieve all five of its outcomes and meet all but one of its output targets.

2. Introduction

2.1. Overview of the project outputs

Engaging Diabetes Communities is a 5-year project running from 28/02/2023 to 27/02/2028. At the time of writing (September 2025), the first 2.5 years of the project have commenced. The project was delivered in Northern Ireland by Diabetes UK with thanks to funding from The National Lottery Community Fund Northern Ireland. This project was delivered by two staff posts: a Diabetes Engagement Officer and a Diabetes Support Worker. This project adopted a volunteer-led and hybrid delivery model. It supported people living with and at risk of diabetes in Northern Ireland through the delivery of nine activities (outputs):

1. **Awareness raising**: Sessions raised awareness of the risks of type 2 diabetes and how to live well with diabetes. *Target: Three per community.*
2. **Building connections**: To locally embed the project, the project built signposting pathways with local healthcare providers, community organisations and employers. *No target.*
3. **Growing a community of volunteers**: The delivery team supported and trained volunteers to become LWAs. Target: *Two LWAs per hub.*
4. **Structured information and peer support sessions**: Structured support sessions delivered on a topic e.g. gestational diabetes. *No target.*
5. **Live Well Hubs**: Hub areas were created to embed diabetes support structures into local communities. *Target: two Hubs created per year.*
6. **Webinars**: Themed awareness sessions with guest speakers. *Target: Four per year.*
7. **Befriender service**: Beneficiaries were matched to a trained volunteer so they could receive one-to-one peer support by regular phone calls or emails. *No target.*
8. **Wellbeing Programme**: Delivered in collaboration with two local mental health charities, Action Mental Health and Aware. *Target: Two programmes per year.*
9. **Peer support groups**: Dedicated groups were set up for different diabetes types to provide a safe space for people to connect and share their experiences on living well with diabetes. *Target: Eight peer support sessions per year.*

2.2. Project outcomes

This project has two outcomes set by the National Lottery Community Fund and three project delivery outcomes:

- **Lottery Outcome 1**: The project will support participants to increase their understanding of diabetes, enabling them to make healthier choices to improve their lives. This improved knowledge, together with the work of volunteers and LWAs in each area, will have a lasting improvement on community infrastructure.
- **Lottery Outcome 2**: The support groups and befriending service will encourage ongoing friendships and connections which will greatly reduce feelings of isolation. This will also help to build and connect communities, empowering them to embed diabetes support.

- **Project Outcome 1**: Increase knowledge and understanding around diabetes, equipping people with information to make better health choices.
- **Project Outcome 2**: Improve health and wellbeing, empowering people to live well with diabetes throughout the pandemic.
- **Project Outcome 3**: Empower communities to stay connected as we recover from COVID, supporting them to embed diabetes support into local infrastructure.

2.3. Project KPI: Engaging Communities will support people living with and at risk of diabetes by delivering over 3,500 interventions during the 5-year project period.

3. Methodology

3.1. Methodology

The interim evaluation of Engaging Diabetes Communities (28/02/2023 - 31/08/2025) was conducted by evaluation consultant Sarita Faulkner using the below methods:

- Regular meetings with the Diabetes Engagement Officer in Northern Ireland.
- Yearly impact presentation meetings with the wider Diabetes UK Northern Ireland team including the National Director.
- Review of the existing data collection and storage tools in use at the beginning of the engagement.
- Review of social media content and analytics collected by Diabetes UK.
- Review of activity (output) data under each outcome collected by the project team.
- 8 online post-activity surveys for project beneficiaries:
    - Befriender Beneficiary Survey.
    - Structured Information and Peer Support Survey.
    - Type 1 or Type 2 Diabetes Peer Support Survey.
    - Remission Peer Support Survey.
    - Wellbeing Programme Survey.
    - Live Well Hub Session Survey.
    - Webinar Survey.
    - Awareness Session Survey.
- An online data surge survey for beneficiaries conducted in Year 2 (using incentives) (N = 65).
- An online data surge survey for project volunteers conducted in Year 2 (N = 4).
- An online data surge survey for healthcare professionals conducted in Year 2 (N = 7).

3.2. Approach

This interim evaluation report covers the first 2.5 years of a 5-year project called Engaging Diabetes Communities. This report will:

- Provide descriptive statistics for data collected in first 2.5 years of the project.
- Use the Year 2 data surge survey as a sample selection of the project beneficiaries.

4. Progress against outputs, outcomes and KPIs

4.1. Delivery KPIs

In the first 2.5 years of project delivery, Engaging Diabetes Communities delivered 5,617 interventions to 3,881 people, of which 641 were people living with or at risk of diabetes (including those living in type 2 diabetes remission). Therefore, **the project has met and exceeded its 3,500-intervention KPI**.

In addition, the project's online content (social media posts and webpage) received reach of 138,077 during the interim delivery period.

4.2. Delivery Outputs

Table 2. Interim project progress against delivery outputs

	No. of activities	No. of interventions	Evaluator's comment
Awareness Raising	99	3,653	**Exceeding target**
Community of Volunteers	23	158	**Below target - area for development**
Structured Info & Peer Support	6	31	**NA – no target**
Live Well Hubs	118	1,249	**Meeting target**
Webinars	11	127	**Meeting target**
Befriender Service	17	128	**NA – no target**
Wellbeing Programme	12	115	**Meeting target**
Peer Support Groups	49	156	**Exceeding target**
Total	**335**	**5,617**	

Under the 'Building Connections' output, the project engaged 137 community organisations and delivered 489 interventions with healthcare professionals (HCPs).

All delivery outputs have met or exceeded the delivery targets. This is with the exception of the 'growing a community of volunteers' output.

The project successfully set up six Live Well Hubs during the interim delivery period. However, it did not meet the target of having two volunteer LWAs per Live Well Hub. Although the Delivery Team recruited and trained 12 volunteers during the first 2.5 years, they were not disturbed across the Live Well Hubs as anticipated. Therefore, this output has been identified as an area of development in the latter half of the project's delivery.

4.3. Outcomes set by The National Lottery Community Fund

As demonstrated by the below table, there is good evidence to support that both outcomes set by the National Lottery Community Fund have been met during the first 2.5 years of project delivery. The evidence to support Lottery Outcome 1 is overwhelmingly strong. Whilst there is good evidence to support that Lottery Outcome 2 is on track to be met, further data to support this outcome in the latter half of the project would be welcomed. This wealth of evidence to support Lottery Outcome 1 can be partially explained by the greater delivery outputs under this outcome in comparison to Lottery Outcome 2 (as expected). With 225 activities and 4,975 interventions delivered under Lottery Outcome 1 vs 110 activities and 642 interventions delivered under Lottery Outcome 2.

Table 3. Interim progress against outcomes set by the National Lottery Community Fund

Lottery Outcome	Evidence to support the outcome	Evaluator's comment
Outcome 1: The project will support participants to increase their understanding of diabetes, enabling them to make healthier choices to improve their lives. This improved knowledge, together with the work of volunteers and LWAs in each area, will have a lasting improvement on community infrastructure.	In Year 2, one beneficiary said: *"Coming [to a Live Well Hub] has been lifesaving."* In Year 3, a beneficiary said: *"I have a better understanding now of how to manage diabetes".* 100% of Year 3 Awareness Session attendees (N = 25) reported: - They'd increased their understanding of diabetes and they felt more confident in making healthier choices to improve their lives. - This project is having a lasting improvement on the diabetes support available within their local community. The Year 2 data surge (N = 65) and the Year 3 Live Well Hub survey (N = 18) found that: - 94% of beneficiaries increased their knowledge and understanding of diabetes. - 89% of beneficiaries were more confident that they could make healthier choices to improve their life. 100% of Year 3 Wellbeing Programme respondents (N = 3) increased their understanding of diabetes and said they had gained information to help them make better health choices.	**Outcome on target**

	100% of people (N = 21) attending a Peer Support Groups in Year 3 increased their understanding of diabetes and felt more confident to make healthier choices to improve their lives. In Year 2, 100% of HCPs (N = 7) and volunteers (N = 4) said this project has had a lasting improvement on the infrastructure for people living with diabetes. 100% of Live Well Hub attendees in Year 3 (N = 18) agreed that this project is having a lasting improvement on the diabetes support available within their local community.	
Outcome 2: The support groups and befriending service will encourage ongoing friendships and connections which will greatly reduce feelings of isolation. This will also help to build and connect communities, empowering them to embed diabetes support.	After attending a Peer Support Groups in Year 3: - 100% of people (N = 21) said they were able to connect with their peers. - 100% (N = 7) reported they'd formed connections and friendships, and felt part of a diabetes community. 100% of Befriender Service beneficiaries in Year 3 (N = 2) said they felt less isolated and more supported with their diabetes. The Year 2 data surge (N = 65) found that: - 83% of beneficiaries had been able to connect with their peers through the project. - 75% of beneficiaries felt less isolated due to the project. 100% of HCPs said the project helped to embed diabetes support into local infrastructure (N = 7). 100% of volunteers said they felt more connected to their diabetes community (N = 4). In Year 1, one Wellbeing Programme beneficiary said: *"[I] feel I am not alone with it. Better educated. Hearing how others cope."* In Year 2, a beneficiary said: *"The group is very good. I don't feel so isolated as nobody at home really understands how you feel and Dr's don't have time to talk to you."* In Year 3, a participant said the project: *"Makes you more aware you are not alone and others share the same problems that come with living with diabetes."*	**Outcome on target**

4.4. Project Outcomes

4.4.1. Outcome 1: Increase knowledge and understanding around diabetes, equipping people with information to make better health choices

There is incredibly strong quantitative evidence to support that Project Outcome 1 has been met during the first 2.5 years of delivery:

- 94% of beneficiaries said they had increased their knowledge and understanding of diabetes in the Year 2 data surge (N = 65) and Year 3 Live Well Hub survey (N = 18).
- 100% of Year 3 Awareness Session attendees (N = 25) said they had increased their understanding of diabetes and they felt more confident making healthier choices.
- 100% of people attending a Wellbeing Programme in Year 3 said they had increased their understanding of diabetes and they had gained information to help them make better health choices (N = 3).
- 100% of those (N = 21) attending peer support group in Year 3 said they'd increased their understanding of diabetes and felt more confident to make healthier choices.

One project volunteer echoed the strong quantitative evidence by saying: *"I feel this project has enlightened people with diabetes on how to care for themselves much better."*

A beneficiary attending the Ballymena Live Well Hub in Year 1 said: *"I can understand food much better. I feel much more confident now, not so scared of having diabetes."*

A Year 2 beneficiary shared: *"The Live Well Hubs are a great support, especially for those newly diagnosed. The Hubs provide up to date information and diabetes management which has been very useful. Shared experiences build confidence and encouragement."*

4.4.2. Outcome 2: Improve health and wellbeing, empowering people to live well with diabetes throughout the pandemic

There is a wealth of evidence to support this project has improved beneficiary's health so that they can live well with diabetes:

- 100% of Year 3 Befriender beneficiaries said the sessions improved their wellbeing and they felt more confident in their ability to live well with diabetes (N = 2).
- 100% of people said the Wellbeing Programme improved their wellbeing and they felt more confident in their ability to live well with diabetes (N = 3).
- The Year 2 data surge (N = 65) found that 85% of beneficiaries were more confident in their ability to live well with diabetes after accessing the project.
- In Year 3, 100% of beneficiaries had improved their wellbeing after attending a peer support group (N = 21) or a Live Well Hub (N = 18).
- 75% of people attending a Year 3 Webinar had improved their wellbeing (N = 3).
- 94% of attendees said Live Well Hubs had made them feel more confident in their ability to live well with diabetes in Year 3 (N = 18).

The World Health Organisation ended the pandemic phase of COVID 3 months after project start. Thus, 'pandemic' terminology was not used in data collection to reflect this change.

There was very strong qualitative evidence from case studies to show that the project had a lasting improvement on several beneficiaries' diabetes and health:

Year 1 case study: "Feeling more confident about diabetes. Since I started coming to the meetings I have lost 14lbs and my HBA1C has gone down to 66 after being over 70."

Year 2 case study: *"[I had an] increase in level of exercise through referral to leisure centre after PARS session at live well hub. I have joined the leisure centre as a member along with my daughter. HBA1C level reduced from 58 to 46 over past 10 weeks."*

Year 3 case study: *"I was able to access a freestyle libre after the [Befriender] phone conversations with the volunteer. It has improved how I manage my diabetes."*

4.4.3. Outcome 3: Empower communities to stay connected as we recover from COVID, supporting them to embed diabetes support into local infrastructure

"Since I have been attending the live well hub, I have made many friends who help and support me on this journey." – Beneficiary living with pre-diabetes in Year 2

"I have been invited to speak at the Live Well hubs and found them to be terrific community groups which really support the members involved." – HCP in Year 2

There is strong evidence to suggest that Engaging Diabetes Communities enabled people to feel connected and part of a diabetes community during the first half of its delivery:

- 100% of people in Year 3 said Live Well Hubs had made them feel part of a diabetes community (N = 18).
- 100% of beneficiaries (N = 7) said after attending peer support groups in Year 3 they had formed connections and friendships, and felt part of a diabetes community.
- 100% of beneficiaries (N = 21) said they were able to connect with their peers during a Year 3 peer support group.
- The Year 2 data surge found 85% of people felt part of a diabetes community and 83% had been able to connect with their peers (N = 65).
- 100% of volunteers felt more connected to their diabetes community (N = 4).

The evaluator concludes that this evaluation period (28/02/2023 - 31/08/2025) can be described as a time during which we are recovering from COVID. Similarly, there was strong evidence to suggest that this project has helped to embed diabetes support into the local infrastructure in Northern Ireland during this period:

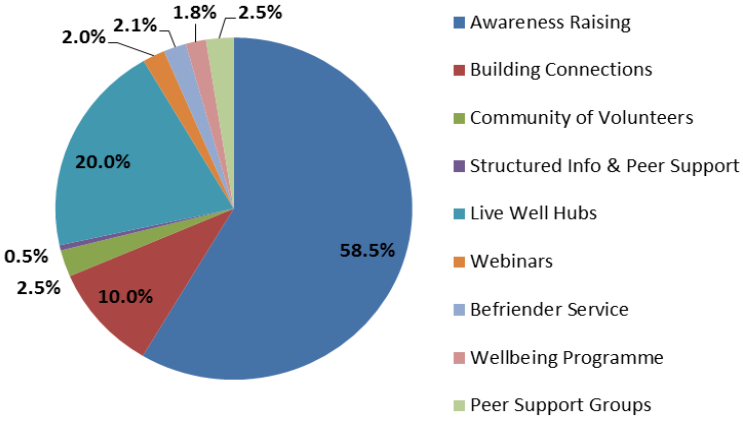
- 100% of Year 3 awareness session (N = 25) and Live Well Hub (N = 18) attendees said the project was having a lasting improvement on the diabetes support available within their local community.
- 77% of Year 3 data surge beneficiaries agreed there was now better diabetes support in their local community due to the project (N = 65).
- 100% of HCPs said the project had helped to embed diabetes support into local infrastructure (N = 7).

5. Interim Evaluation

5.1. KPI: The project exceeded its 3,500-intervention KPI target by 60.5%.

5.2. Delivery outputs: The project successfully mobilised delivery of all nine delivery outputs. All but one delivery output (growing a community of volunteers) was on track. Pie chart 1 shows that Awareness Raising (58.5%), Live Well Hubs (20%) and Building Connections (10%) made up the greatest proportion of interventions – demonstrating a hub and spoke delivery model. The lowest area of delivery was Structured Info & Peer Support Sessions (0.5%).

Pie Chart 1. Interventions delivered against each project activity



5.3. Lottery outcomes: There is strong evidence to demonstrate that Lottery Outcome 1 is on track to be met by project end and there is good evidence to support that Lottery Outcome 2 is on track to be met. Outcome 2 could benefit from additional impact data.

5.4. Project outcomes: There is very strong evidence to support that all three project outcomes are on track to be met by project end.

5.5. Project adaptability: The project made nine adaptations during its first 2.5 years in response to feedback. Key adaptations included: new focus areas; walking groups; changes to volunteer recruitment and training; and trialling evening Live Well Hub delivery.

5.6. Deprivation delivery analysis: Analysing the location of the six Live Well Hub areas against the Northern Ireland Multiple Deprivation Measure 2017 revealed that five areas were in the top 30% most deprived areas in Northern Ireland including the Belfast Live Well Hub which was located in the top 1% most deprived areas. Only the Newry Live Well Hub was located in one of the 20% least deprived areas in Northern Ireland.

5.7. Year 2 data surge sample analysis: In Year 2, a data surge survey was conducted to collect a sample of beneficiaries. 65 valid responses were received, representing 13% of the beneficiaries living with or at risk of diabetes (including remission) who had participated in the first two project years. The sample showed a commonly reported gender bias (Becker, 2022) for online surveys with 63% of the sample identifying as female and 37% as male. More notably, the sample showed that 46% of respondents were over 66 years old. When the age of respondents was mapped against the global age distribution for diabetes (IDF, 2021), it showed that the project is reaching a higher proportion of younger and older people living with diabetes. This implies that the project may be underserving middle aged adults living with diabetes (aged 36-65).

6. Recommendations and Conclusion

6.1. Recommendations

Table 4. The evaluator's recommendations for the second half of Engaging Diabetes Communities	
Recommendation	**Description and Rationale**
Explore new ways to engage people aged 35-65	The Year 2 data surge suggested that the project could be underserving middle aged adults. The project adaptation log also collected feedback suggesting people wanted evening Live Well Hub Sessions due to their work commitments. However, when evening sessions were provided, no one attended. Therefore, the evaluator recommends the Delivery Team continue to explore ways to engage the middle and working age population. For example via evening sessions (trial novel advertisement methods e.g. employer partnerships), weekend sessions and standalone sessions.
Collect more data on the mechanisms of infrastructure change	There was strong evidence showing the project has had a lasting improvement on community infrastructure. However, at present there is little understanding on how exactly this complex, nine-activity project is creating this lasting change. To enhance future iterations of this project, the evaluator recommends more data collection is conducted on how this change is coming about. For example, by capturing the perspectives of HCPs within the diabetes infrastructure.
Enhance data collection around tackling inequalities	The Delivery Team wanted to understand if the project is supporting those facing inequalities. Other than the Live Well Hub location data, there is there is limited evidence test this. Hence, the evaluator recommends exploring this in future data collection. For example by including a self-reported measure of socioeconomic status in future data surges.
Begin impact measurement with community partners	Engaging Diabetes Communities has engaged 137 community organisations in its first 2.5 years. At present, little can be understood about the impact of these partnerships. The evaluator suspects that positive impact could be going uncaptured. Thus, they recommend running a new survey to capture the experiences of said community organisations.
Continue exploring ways to recruit and retain LWAs	As previous highlighted, the project has a lower number of LWAs then planned. As such, the evaluator recommends the Delivery Team continue to explore ways to increase LWA volunteering. For example by: exploring alternative recruitment methods; reviewing the roles and responsibilities of a LWA to increase accessibility; review training and promote skills development opportunities; and offering more diverse hours to accommodate different life-stages.

6.2. Conclusion

In its first 2.5 years, Engaging Diabetes Communities has supported 3,881 people in Northern Ireland through 335 activities delivering 5,617 interventions. At this interim stage, the project is on track to exceed its KPI, achieve all of its outcomes and meet all but one output target. There is a wealth of evidence to show this project is increasing understanding of diabetes, improving health, reducing isolation, helping to create a diabetes community and making a lasting difference to the local diabetes infrastructure in Northern Ireland.