healthwatch
Sandwell

Diabetes In Sandwell
March 2024

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Executive summary

Healthwatch Sandwell is an independent organisation that champions the voice of Sandwell residents in their health and social care services. Experiences and insight gathered from engaging and listening to people is shared with health and social care providers and commissioners to help inform and improve services.

10.1% of Sandwell adult patients are recorded as having diabetes exceeding the West Midlands average of 8.2% and the national average of 7.3%.[1] Sandwell figures are projected to increase to 11.4% by 2030.[2]

Successful management of living with diabetes and reducing associated health risks requires patient and health care services to work together. NHS healthcare services have a responsibility to ensure patients are offered diabetes management education, so that they are well informed and able to be involved in managing their condition and decisions about their care, including medications. The National Institute for Health and Care Excellence (NICE) guidance also recommends an individualised approach, is required to meet any patients' needs and circumstances including dietary advice, culture and beliefs.[3]

Diabetes UK research highlights concerns around diabetes complications and care in the older population, especially frail elderly.[4] Also that some ethnic groups are at higher risks of development of diabetes and at an earlier age than the White population including African, African Caribbean and South Asian communities (Indian, Bangladeshi and Pakistani).[5]

Raising awareness of diabetes in communities and prevention work with patients diagnosed as pre-diabetic is key to minimising risk of development of type 2 diabetes and reducing the percentage of patients with diabetes in Sandwell and consequent demand on diabetes health care services.

Healthwatch Sandwell worked in partnership with Diabetes UK, some Voluntary Community Organisations and NHS primary care services to engage with Sandwell residents affected by diabetes and pre-diabetes to gather the picture for Sandwell.

The key findings have informed the recommendations which include:

- Increased information promotion, awareness raising and education on diabetes and risks
- A holistic partnership approach to diabetes prevention and risk reduction services
- Improvements to health care services including staff diabetes awareness training
- A focus on meeting specific needs for groups at higher risk of developing diabetes or challenges with managing the condition
- Increases in support services for individuals and communities living with and managing diabetes

The main body of the report (pages 5-41) includes an overview of health care services for pre-diabetes and diabetes, patient experiences and feedback on services and of self-management of the condition.

Sandwell residents and patient voices and views are included in the main report.

Conclusions

"Prevention is better than cure!"

A focus on increasing awareness and education of diabetes risks within Sandwell communities, through targeted work, is key to reducing growth in the number of patients living with type 2 diabetes in Sandwell in the future and subsequent impact on health care resources.

Quality information about diabetes and risks, in a variety of formats, needs to be visible and accessible across Sandwell for all members of the population. Working in a holistic partnership approach can ensure this and tailor focused services to groups with higher risks of developing diabetes or those struggling to self-manage the condition for reasons highlighted within the report.

Findings in the report, capturing patient feedback and monitoring of diabetes health care checks performance, will help identify areas for improvement and gaps in services requiring development, for example dietary advice services and mental wellbeing support.

Health and wellbeing support services are available across Sandwell. This report highlights a need for continuing Sandwell Council public health community outreach services and to developing a strategic approach to help ensure individuals and communities in Sandwell feel connected, supported, enabled and empowered to be able to take appropriate levels of responsibility for their own health and wellbeing.

Through a preventative agenda focus it should be possible to reduce the percentage of new patients diagnosed with type 2 diabetes, and the current poor performance levels, compared to regional and national average across Sandwell. Healthwatch Sandwell hopes the patient voices and findings reflected within this report have helped to demonstrate that.

Recommendations

Healthwatch Sandwell request that Sandwell Health and Wellbeing Board, Sandwell Health and Care Partnership and Black Country Integrated Care Board:

Consider and formally acknowledge the Diabetes report findings and respond to the proposed recommendations including confirming responsibility and accountability procedure for any service improvements.

The report recommendations have been categorised and presented in the next pages. They have been identified and informed by the project findings and feedback from Sandwell residents and are included within the main body of the report in the relevant locations.

Sandwell Health and Wellbeing Board

1. Consider the diabetes report findings and with Sandwell Health and Care Partnership identify a partnership approach to developing improvements to diabetes services and holistic support for Sandwell residents and communities in managing the condition and risks.

Sandwell Health and Care Partnership

2. Consider the extent of diabetes risk and prevention information visibly available across Sandwell, including accessibility of formats to meet needs, and seek to increase supply, distribution, promotion and up-take of information.

3. Consider the feedback from pre-diabetes patients and explore opportunities and feasibility for development of a pre-diabetes support contact service.

4. Ensure that all patients diagnosed with diabetes receive the Diabetes UK booklets on "What care to expect" and are clear about the annual diabetes health checks appointment booking procedures.

5. Note the findings in this report, review the dietician and nutritionist service offer available in Sandwell for supporting people with diabetes, and identify and make improvements.

6. Consider the findings relating to elderly people and potential impacts on management of diabetes identifying any possible improvements to care and support services for patients and family carers.

7. Consider the initial findings in this report and plan to engage with patients during and post gestational diabetes to help inform and improve services and patient diabetes risk awareness and management.

8. Consider the feedback on support groups and identify opportunities for increasing the offer across Sandwell, ensuring all support groups are adequately trained and supported with diabetes resources.

9. Consider feedback from patients on mental wellbeing within the report and identify opportunities for increasing the support offer at diabetes diagnosis and during patient self-management of the condition.

10. Consider the insights relating to men managing diabetes and identify opportunities for targeted engagement and support for diabetes management.

11. Consider the findings in this report relating to ethnic communities at higher risk of diabetes and develop a collaborative action plan for improvements in diabetes health, care and support services offers, including targeted diabetes awareness raising, information provision and risk screening.

12. Enable and empower local communities at "grass roots" level on awareness raising of diabetes prevention and risk management and practically support initiatives for living healthily with diabetes.

Black Country Integrated Care Board

NHS health care service commissioners:

13. Review procedures for pre-diabetic patients who have not received at least an annual HbA1c blood test and address gaps.
14. Consider procedures to ensure all patients registered with diabetes are receiving the full range of diabetes checks.
15. Consider the patient feedback relating to diabetes health checks and identify opportunities for improvements to services, including a continuation of diabetes awareness raising and training within primary care services.

Service commissioners:

16. Consider outcomes monitoring for referral, uptake and patient satisfaction of diabetes prevention programmes, ensuring service delivery is personalised to meet needs.
17. Consider the report findings and extent of information provided to patients diagnosed with diabetes, identify and deliver improvements, ensuring individual needs are met.
18. Review process and extent of diabetes patient referral to structured education courses through NHS health care services including uptake and quality checking through patient satisfaction feedback.
19. Explore opportunities for development of a Diabetes Community Champion programme delivered through Diabetes UK, identifying target communities and delivery partners with Sandwell Health and Care Partnership.

The project findings and main body of the report are contained in the next sections (pages 5-41).

Introduction – diabetes and Sandwell context

What is diabetes?

The NHS website explains diabetes and main types:[6]

Diabetes is a condition that causes a person's blood sugar levels to become too high. The amount of sugar in the blood is controlled by a hormone called insulin, produced by the pancreas (a gland behind the stomach). When food is digested and enters the bloodstream, insulin moves glucose out of the blood into cells, where it is broken down to produce energy. If a person has diabetes, their body is unable to break down glucose into energy. Because of not enough insulin to move the glucose, or the insulin produced does not work properly.

Main types of diabetes:

Type 1 diabetes - a lifelong condition where the body's immune system attacks and destroys the cells that produce insulin. It affects about 10% of adults with diabetes in the UK.

Type 2 diabetes - where the body does not produce enough insulin, or the body's cells do not react to insulin properly. In the UK, over 90% of all adults with diabetes have type 2.

Gestational diabetes - high blood sugar that develops during pregnancy and usually disappears after giving birth.

Non-diabetic hyperglycaemia (pre-diabetes) – blood sugar levels above the normal range, but not high enough to be diagnosed as having diabetes. A greater risk of developing type 2 diabetes, but the risk can be reduced through lifestyle changes.

Diagnosing and managing diabetes

Diabetes and pre-diabetes is diagnosed by blood tests usually HbA1c blood test or a fasting plasma glucose test.[7] Monitoring and managing blood sugar (glucose) levels is important for controlling diabetes and lowering risks of health complications.

Insulin injections are required to manage type 1 diabetes. People diagnosed with type 2 diabetes may be able to manage their condition and reduce their risk levels by healthy eating, regular exercise and maintaining a healthy body weight. However, many people with type 2 diabetes, may also need to take medication by tablet or injection, which may include insulin.

NHS healthcare services need to work together with the patient to manage their diabetes condition. NHS services should ensure patients are well **informed** about diabetes and **involved** in developing **personalised** diabetes management and care that meets their needs.

Information to support diabetes risk and management

Diabetes UK is the leading charity for people living with diabetes in the UK.[8] They provide free information on diabetes risks, prevention, and living with and managing diabetes. They also offer a Diabetes UK Helpline.[9]

There are a variety of diabetes management courses available to support people diagnosed as diabetic or pre-diabetic, including through NHS healthcare services referral.

Higher risk groups

General risks

NHS website information states people are more at risk of type 2 diabetes if they:

- have high blood pressure
- take certain medicines such as steroids for a long time
- have a family history of type 2 diabetes
- have had gestational diabetes during pregnancy
- are of Asian, Black African or African Caribbean origin[10]

Ethnic communities

Diabetes UK Tackling Inequality Commission Report November 2023 highlights that:

People from **Black African, African Caribbean** and **South Asian (Indian, Pakistani, Bangladeshi)** backgrounds are at a higher risk of developing type 2 diabetes and from a younger age, for South Asian ethnicity also at a lower BMI.[11]

Diabetes can develop in Black and South Asian people at a younger age, around 25 years old compared to 40 years for the White population.[12]

Older people

Diabetes UK states that over a third of people living with diabetes in the UK are over 65 years old and highlights that there are gaps in research and unanswered questions around increased risks and complications of managing diabetes as people become older, in particular elderly or vulnerable.[13]

Diabetes in Sandwell – statistical data

10.1% of patients over 17 years old registered with NHS GP practices in Sandwell are recorded as having diabetes. This is higher than the West Midlands at **8.2%** and the National average at **7.3%.**[1] Projections are for an increase to 11.4% of patients by 2030.[2]

Additionally Sandwell performs poorly on interrelated health conditions, has lower healthy life expectancy and a higher level of preventable deaths than national figures.

Sandwell Trends data states:[14]

- Life Expectancy at birth in Sandwell is 76.1 years for males and 80.7 years for females. Compared to 79.4 for males and 83.1 for females in England. (Fingertips PHE, 2018/20)

- Sandwell is an ethnically diverse borough. 48% of residents are from black and minority ethnic communities. This compares to 26% in England and Wales. (2021 Census)

Healthwatch Sandwell Priority Project

Healthwatch Sandwell priority project for 2023/24:

Exploring the picture of diabetes in Sandwell, patients experiences of diagnosis, health, care and support services and living with and managing the condition.

The project focused on:

- Pre-diabetes – diagnosis, prevention and support
- Information and education on diabetes risk and management
- Sandwell residents' experiences of living with and managing diabetes
- Health, care and support services to help manage diabetes
- Experiences of diabetes in Black and South Asian communities
- Gathering insight on living with and managing diabetes as people age.

This report includes:

- Overall project findings
- Sandwell residents' experiences, voices and views
- Focus Group conversation insights for higher risk groups
- Highlights of gaps in services
- Recommendations for development and improvement of health, care and support services for diabetes prevention and management.

What we did and who we talked to

Working in partnership to gather the picture on diabetes and pre-diabetes in Sandwell

Project approach

Around 10% of Sandwell residents have been diagnosed with diabetes, and a further number with pre-diabetes. We wanted to ensure that we connected with as many residents affected by diabetes as possible. We embedded the priority project into our overall work programme and focused project plans to target relevant health, care and support services. The project approach included:

- Partnership working with professionals in health, care and support services
- A questionnaire
- Enter and View programme
- Individual conversations
- Focus Group conversations

Partnership working

Healthwatch Sandwell developed a working relationship with Diabetes UK which included working together on project engagement supported by organisations in the Voluntary Community Sector:

Some Sandwell NHS primary care services directly supported the project, details are outlined in the next sections.

Questionnaire

A questionnaire was designed for completion by Sandwell residents diagnosed with diabetes or pre-diabetes to capture insight on:

- Patient experiences of diagnosis and health and care services
- Diabetes information, courses and support provided/referrals
- Pre-diabetes awareness and understanding of diabetes risks
- Experiences of self-management of diabetes or pre-diabetes
- Feedback and views on support services to help manage and prevent diabetes

The questionnaire was available in printed format and on-line with a QR code promoted.
Your Health Partnership (YHP) are a network of primary care GP Practices.[15] YHP supported the project by sending patients with diabetes, or pre-diabetes, a link to the online questionnaire on their mobile phones.

Enter and view programme

Part of Healthwatch Sandwell remit is to carry out Enter and View visits, which help identify what is working well with services and where things could be improved. Our Enter and View programme complemented the diabetes project. We visited premises that included services for patients with diabetes such as phlebotomy, eye clinics and foot clinics.[16]

The Enter and View programme provided opportunity to also engage with patients about the diabetes project. Some staff at the Diabetes Clinic.[17] at Sandwell Hospital and the Foot Health Clinic[18] at Victoria Health Centre provided professional insight on managing diabetes which is reflected within this report.

GP practice engagement

Healthwatch Sandwell aim to work collaboratively with Sandwell Primary Care Networks to engage with patients and gather experiences, voices and views on services to inform and improve health, care and support services in Sandwell.

Some Primary Care Networks support patient engagement through waiting rooms, clinics, health awareness events and Patient Participation Groups (PPG). Healthwatch Sandwell GP showcase initiative included working with Bearwood Medical Centre on a PPG relaunch and diabetes awareness work.[19]

Individual conversations

Healthwatch Sandwell core services include engaging, talking and listening to Sandwell residents about their experiences of health and care services. This has provided opportunities for individual conversations with people diagnosed with diabetes or pre-diabetes, helping gather insight for the diabetes project. We have also been active in raising awareness of diabetes, risks and prevention and promoted Diabetes UK information.

Focus Group conversations

The project focused on three groups of people affected by diabetes, gathering a deeper insight on whether health, care and support services are meeting needs. The Focus Groups were:

- Older People
- African/African Caribbean communities
- South Asian communities

We recruited relevant people to each of the Focus Groups, inviting them to group conversation events and holding individual conversations with others who were unable to join group events.

Pre-diabetes – services and patient experiences

A focus on prevention work can significantly reduce risks of developing type 2 diabetes.

Assessing diabetes risk

Sandwell residents can check their risk of developing type 2 diabetes, or if in the pre-diabetic range by:

- Completing the Diabetes UK 'Know Your Risk' tool[20]
- Free health care testing for Sandwell residents (available for ages 40-74 years old) – includes assessment of risk type 2 diabetes, cardiovascular disease, high blood pressure.[21]
- A HbA1c blood test or a fasting plasma glucose test to check diabetes risk.

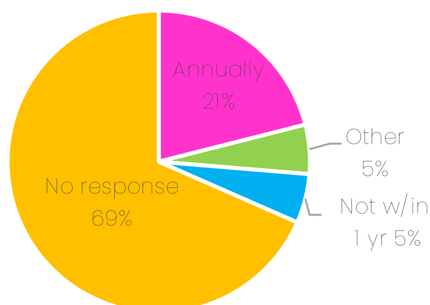
The NHS recommends that people with non-diabetic hyperglycaemia (pre-diabetes) have a blood test every year to monitor their blood sugar levels.

Project Questionnaire:

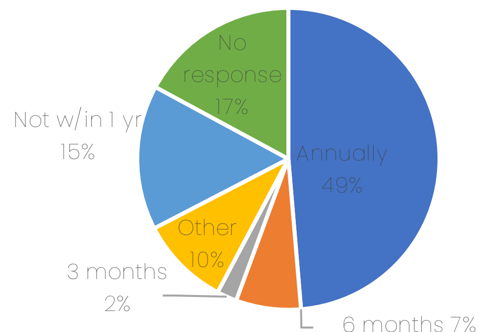
"How often have you had a HbA1c blood test?"

The profile of responses for HWS (from patients of GP practices across Sandwell) and YHP patients differ. This may indicate variation in policies for monitoring of pre-diabetic patients between GP practices.

Pre-diabetic - HbA1c blood test (HWS)



Pre-diabetic - HbA1c blood test (YHP)



Project Questionnaire:

"Do you intend to ask for a blood test in the future to manage your pre-diabetes?"

Responses received: **47% Yes**, **8% No** and **26% unsure**

Recommendation:

BC ICB NHS Health care service commissioners review procedures for pre-diabetic patients who have not received at least an annual HbA1c blood test and address gaps.

Providing information

National Institute for Health and Care Excellence (NICE) Type 2 diabetes prevention recommendations (for all diagnosed pre-diabetic patients) include discussion and information about diabetes risk factors and lifestyle improvements.[22]

NICE guidance on diabetes risk assessment also recommends that service providers including pharmacists, managers of local health and community services and voluntary organisations, employers and leaders of faith groups should offer validated self-assessment questionnaires or validated web-based tools. They should also provide the information needed to complete and interpret them. The tools should be available in local health, community and social care venues.[23]

Sandwell Council – Healthy Sandwell services provide diabetes prevention information to Sandwell residents, including through public engagement events, website information and provision of Diabetes UK information links and resources.[24]

Free information resources that can be obtained from the Diabetes UK website include:

Information on pre-diabetes and managing risks of developing type 2 diabetes[25]

Type 2 diabetes – know your risk (order from the website or downloaded as PDF)[26]

Type 2 diabetes 'Know Your Risk' (web based tool)[20]

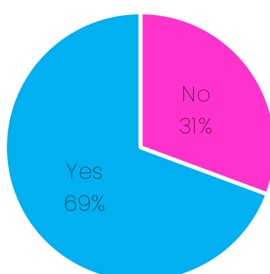
During engagement on the diabetes project Healthwatch Sandwell promoted and provided Diabetes UK information. We found that many people were not previously aware that such information was available.

We also noted a general lack of visible promotion or availability of diabetes awareness and prevention information within Sandwell communities.

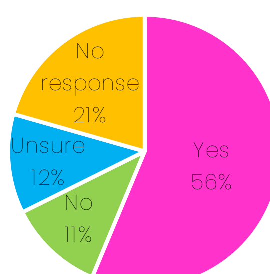
Project Questionnaire: **Asked patients diagnosed with pre-diabetes about their experiences of obtaining information about pre-diabetes and diabetes risks.**

238 responses

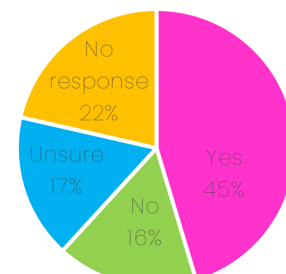
Given/signposted to information to understand pre-diabetes and risks



Know where to go for information on diabetes risks



Feel well informed about pre-diabetes/managing diabetes risk



"I was told that I'm pre-diabetic just before the pandemic. No advice given and they haven't bothered to check on me."

Project Questionnaire:

Asked if patients had undertaken some of their own research on pre-diabetes and diabetes risks.

238 responses

- 34% said that they had undertaken some of their own research
- 14% of all respondents stated they had looked up information on the internet
- 3% stated Diabetes UK as their self-directed source of information

"Relatives & library books."

"A friend who was diabetic guided me through information and processes."

Recommendation:

Sandwell Health and Care Partnership consider the extent of diabetes risk and prevention information visibly available across Sandwell, including accessibility of formats to meet needs, and seek to increase supply, distribution, promotion and up-take of information.

Diabetes risk prevention

National Institute for Health and Care Excellence (NICE) type 2 diabetes prevention recommendations for pre-diabetes interventions depend on the risk level diagnosis:[27]

Low: Provide information and signpost to wellbeing support in the community

Moderate: (a high risk score, but with a fasting plasma glucose less than 5.5 mmol/l or HbA1c of less than 42 mmol/mol [6.0%]) – offer brief interventions e.g. exercise classes, weight-loss programmes via social prescribing.

High: (a high risk score and fasting plasma glucose of 5.5-6.9 mmol/l or HbA1c of 42 to 47 mmol/mol [6.0% to 6.4%]) – offer a referral to a local, evidence-based, quality assured intensive lifestyle change programme. Give details of where to obtain independent advice from health professionals.

"The GP phone consultation felt rushed, told to watch what I eat, exercise more. It was a shock to be diagnosed as pre-diabetic, didn't know what questions to ask or where to go for more information."

Pre-diabetes support

Sandwell Council – Healthy Sandwell services informed Healthwatch Sandwell that they receive a high number of referrals from GP practices each week relating to pre-diabetes. The Healthy Sandwell team help connect Sandwell residents to support services and have a dedicated diabetes prevention website page.[24]

Project Questionnaire: "What support services have worked well for you in helping manage your health and wellbeing related to pre-diabetes?"

238 responses

- The majority replied "none" as they had not received any support
- Many made comments about difficulty accessing GP practice appointments.

"Joined Halesowen leisure centre."

Project Questionnaire:

"What support services would you like to access, or see improvements in, for diabetes prevention?"

Healthy eating and weight management:

"How to eat well and maintain a healthy weight."

"Mental health discussions to control eating and weight."

"Help with gym membership."

"More places to go. Courses and classes to help keep it under control."

Contact service to monitor and support management of pre-diabetes:

"A follow up to see how I am getting on."

"Being able to have advice from a nurse."

"One to one chat to doctor every 6 months."

"Awareness clinics every now and then either in health centres or GP practices."

"Access to a human being who can provide me with an overview of my health and wellbeing as a whole "full picture" style and signpost/refer me on."

"It would be good to have face to face contact instead of on-line contact. I don't have a computer or understand how to access on-line things."

Sandwell Diabetes Clinic told Healthwatch Sandwell that a previous NHS services model that worked well included diabetes support nurses and community dieticians that GP practices could refer pre-diabetic patients to for education and support.

Sandwell Primary Care Network services may include specialist services that could support pre-diabetic patients. However feedback indicates inconsistency in patient experience and GP Practice service offers.

Recommendation:

Sandwell Health and Care Partnership consider the feedback from pre-diabetes patients and explore opportunities and feasibility for development of a pre-diabetes support contact service.

NHS diabetes prevention programme

Patients with pre-diabetes may be eligible for the NHS Healthier You – Diabetes Prevention Programme which states that it cuts the risk of developing type 2 diabetes by more than a third for people completing the programme.[28]

In Sandwell, and the Black Country, the programme is commissioned and delivered by Living Well, Taking Control.[29] The programme is delivered over a 9 month period through group sessions or on a one-to-one basis via Liva app[30] or other digital options designed to meet sensory needs or language barriers.

The eligibility criteria for referral to the course match NICE guidelines high risk scores:

- HbA1c between 42-47mmol/mol (6.0-6.4%) or Fasting Plasma Glucose (FPG) between 5.5-6.9mmols/l within the last 12 months;
- or has a history of Gestational Diabetes Mellitus (GDM) and normoglycaemia (HbA1c < 42 mmol/mol (< 6.0%) or FPG < 5.5mmol/l)

Referral to the Living Well, Taking Control programme is via a GP or health professional, or patients can self-refer (a letter or text from their GP with the latest HbA1c or fasting plasma glucose reading is required).[31] Healthwatch Sandwell noted that website information links to the self-referral process are convoluted.

Patient experience: Course referral eligibility

Mrs A is in her early 70's with a family history of diabetes. Mrs A had a HbA1c blood test reading of 48 mmol and was referred onto the diabetes prevention programme. However 48 mmol was outside the range of pre-diabetes eligibility criteria, so the referral was rejected. There was a 6 month delay in communicating this to Mrs A and subsequent blood tests resulted in Mrs A being diagnosed with type 2 diabetes.

Patient feedback on the diabetes prevention programme

"I was diagnosed 3 years ago with pre-diabetes and was sent on a course that was quite informative. I was able to get out of pre-diabetes."

"Pre-diabetes programme helped. I found out about the fat, sugar and salt in ready meals!"

"6 week course was good. They explained things and gave out paperwork to reference back to."

"Sent on 12 week course. Very informative with an information booklet. Surprised about fruit juices."

Healthwatch Sandwell also heard that the pre-diabetes programme offer did not meet everyone's needs, including delivery format, insufficient information for cultural diets and, for some, language barriers.

"Phone support group. Didn't like it as it seemed to be the same people talking."
"I don't know what foods I am allowed to eat!" (South Asian woman)

Recommendation:

BC ICB Service commissioners consider outcomes monitoring for referral, uptake and patient satisfaction of diabetes prevention programmes, ensuring service delivery is personalised to meet needs.

Living with diabetes – services and patient experiences

Gathering the picture

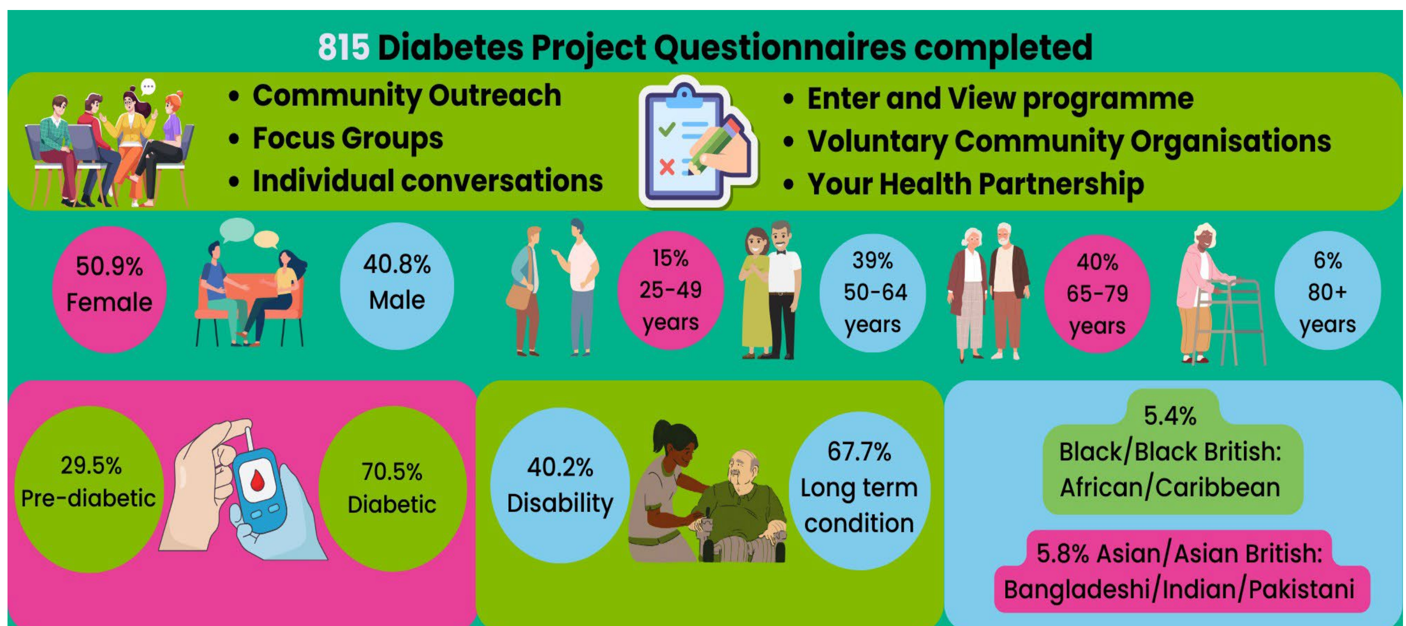
The next sections of this report look at patient experiences of:

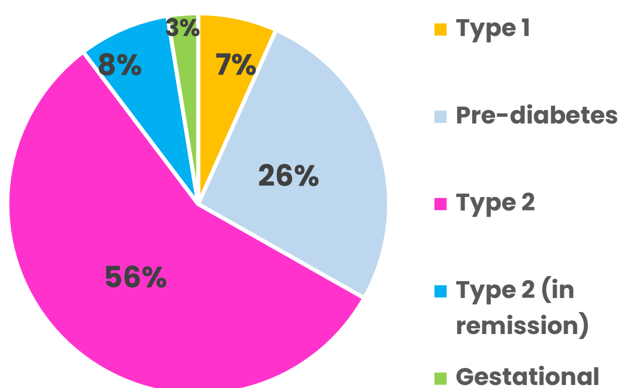
- Health care services for managing diabetes
- Patient self-management of diabetes
- Support for self-management of diabetes

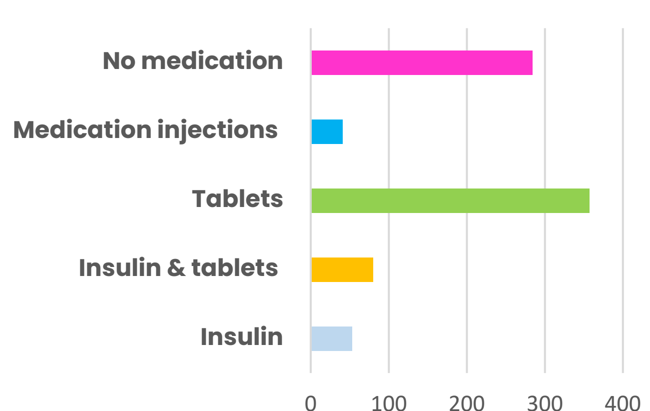
The patient experiences and insight shared is based on the project questionnaire findings and individual conversations with Sandwell residents with, or affected by diabetes, and health, care and support service providers.

Healthwatch Sandwell heard about the experiences of some people with type 1 diabetes and feedback is included. However the main focus of insight and recommendations within this report relates to the experiences of people with type 2 diabetes, which represents around 90% of UK diabetes patients.

Questionnaire







Questionnaire results analysis

815 people responded to the diabetes project questionnaire – the overall results are based on:

- 111 responses received by Healthwatch Sandwell (HWS) – patients across Sandwell GP practices
- 704 responses based on Your Health Partnership (YHP) – patients with diabetes or pre-diabetes within their Primary Care Network who were sent a link to the questionnaire via mobile phone.

To note:

Where HWS questionnaire responses and YHP results were broadly similar the results were combined to provide overall average percentage figures.

Where there were notable variances in HWS and YHP responses the results have been shown separately. HWS did not explore the reasons for the differences in the results though it might be useful for primary health care services and commissioners to do so.

YHP informed HWS that they have been allocated some diabetes transformation funding which is planned to be utilised to share diabetes knowledge from within YHP teams to upskill primary care staff, including community nurses, and for diabetes buddying schemes.

Patient experiences of living with and managing diabetes and of health, care and support services to help manage the condition are reflected within the next sections of this report.

Health care services and patient relationship

The NICE guidance "Type 2 diabetes the care you should expect" states that patients should:[3]

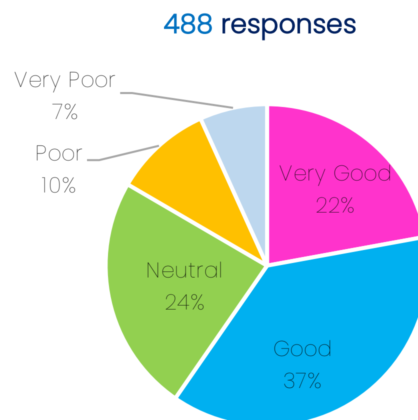
- have the right to be involved in discussions and make informed decisions about their care, including blood sugar targets and joint agreement on medications.
- be offered structured education to adults with type 2 diabetes and their family members or carers (as appropriate) at the time of diagnosis, with annual reinforcement and review.
- should receive a personalised individualised approach to diabetes care, tailored to the patients' needs and circumstances including meeting any disability and impairment needs
- receive individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition. Dietary advice to be provided in a form sensitive to a person's needs, culture and beliefs, being sensitive to their willingness to change and the effects on their quality of life.

Involved and informed

Project Questionnaire - Please rate the statement:

"I have been given enough information to understand and manage my diabetes."

488 responses



"A 10 minute consultation to get your head around changing diet and doing more exercise is not enough to take in a diabetes diagnosis."

"I have had to do all my own research about diet to try and get on top of my sugars as no information on diet has ever been given me."

"Not sure about new medications that are developed, I read things in the press, but still take the same medication."

"I saw the Diabetic Nurse, I hadn't met him before, he listened to all I had to say."

"I have not seen a diabetes specialist in over 12 years. I have a lot of problems, but the staff have no time to listen or help."

Older patient - newly diagnosed:

"I did not know I was being tested for diabetes. GP rang out of the blue and told me I was diabetic. I asked what it meant and was told not to eat any carbs. That was it! I had to request to get more info from a diabetic nurse, I had to insist to see a nurse, she spoke to me on the telephone. I have seen a practice nurse twice since after again requesting a consult."

The Diabetes UK website provides information on the range of types of diabetes and managing the condition.[32] The information is available online including in other languages and accessible formats including sub-titled and British Sign Language. Most information can be ordered in free booklet format or downloaded as a PDF document.[49]

Recommendation:

BC ICB service commissioners consider the report findings and extent of information provided to patients diagnosed with diabetes, identify and deliver improvements, ensuring individual needs are met.

Education

Main education programmes referenced by patients were:

- DESMOND – NICE approved course – 6 hours education[33]
- X-PERT - session over 6 weeks with annual follow up session[34]
- DAFNE – Type 1 diabetes management[35]

"Diabetes Clinic at City Hospital. Good information on diabetes. Do not need to attend anymore."

"I asked my GP nurse about the diabetes X-pert courses, they did not know anything about them and would not refer me to them."

Healthwatch Sandwell heard positive feedback from a few patients with long-standing diabetes who had attended the X-PERT course. Some people mentioned DESMOND and DAFNE courses but overall there was little feedback from diabetes patients relating to education courses.

Some patients referenced being referred to Oviva diabetes courses but had mixed experiences.[36]

"I was referred to Oviva, but I can't use technology. The phone system was confusing. I had a half hour phone support and was told I would be called again in 3 months-time."

"Oviva services and app really helped with changing diet, monitoring and support. Would recommend this to anyone. Still use the app to record food drink and weight. Easy to use and helpful to track lifestyle choices."

"The Oviva app kept dropping off my phone and I lost all the study progress to date."

Recommendation:

BC ICB service commissioners review process and extent of diabetes patient referral to structured education courses through NHS health care services including uptake and quality checking through patient satisfaction feedback.

Individualised and dietary advice

"I am recorded on my NHS records as Deaf and needing an interpreter - this is provided at each service - shared care records are working." (Dr Arora's Surgery)

"Dietary advice that is tailored to what I eat."

"Was told nothing about diabetes, was to be referred to a diabetic dietitian - still waiting."

"Hospital support was good. They gave me advice and I stopped eating fried foods."

"Sent on a course at Sandwell Hospital. Good, but it didn't suit my dietary habits."

"I have multiple health conditions, despite requesting referral to a dietician my GP won't refer me."

Patient struggle with support for multiple health conditions

Ms A has struggled enormously to manage both diabetes and diverticulitis and received very little personal support from the GP or nurse in managing the combination of the two conditions. The diabetes medication had an adverse impact on the diverticulitis, which Ms A feels that she was ignored by her GP practice. Ms A said the Finch bowel nurses[37] provided a much more personal and regular service and provided more support to help manage her diabetes.

Recommendation:

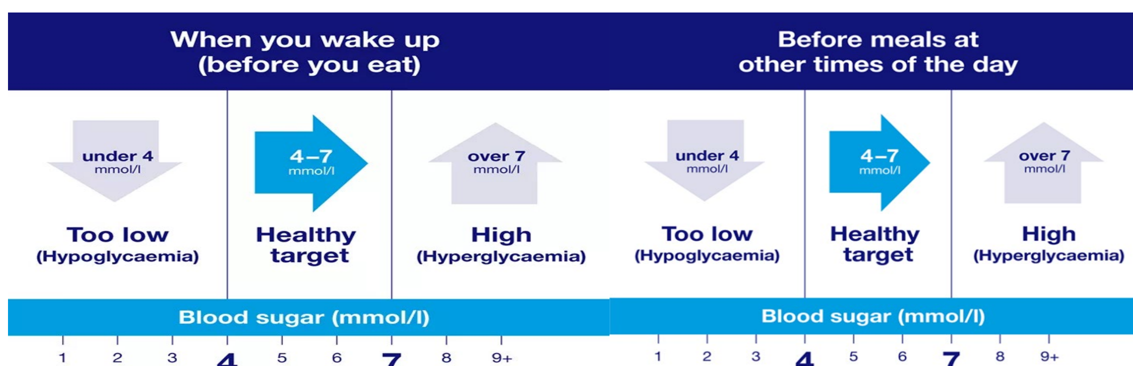
Sandwell Health and Care Partnership note the findings in this report, review the dietician and nutritionist service offer available in Sandwell for supporting people with diabetes, and identify and make improvements.

Health care services - diabetes management

Monitoring blood sugar levels

Monitoring and managing blood sugar (glucose) level ranges is important for managing diabetes and lowering risks of health complications. Each person is individual so normal healthy blood sugar ranges can vary from person to person. Diabetes UK website provides information on checking blood sugar levels:

Diabetes UK normal blood sugar ranges:



People with diabetes can self-monitor their blood sugar levels by a finger-prick test. Blood glucose levels can also be monitored by a body sensor - Flash Glucose Monitor or Continuous Glucose Monitor.[38] The monitors should be prescribed free to people with type 1 diabetes depending on NHS eligibility criteria.[39]

Patients with diabetes have HbA1c blood tests to monitor blood sugar (glucose) levels taken as part of their diabetes health care services every 3-6 months depending on their diabetes stability.

Diabetes health checks

Each patient with diabetes should receive an annual review - checks to monitor their overall health and diabetes risk factors. Some patients require more regular monitoring of their diabetes condition, so may receive these checks more often.

The NICE guidance - Type 2 diabetes the care you should expect[3] is summarised by Diabetes UK:[40]

Each year, everyone with diabetes should receive:

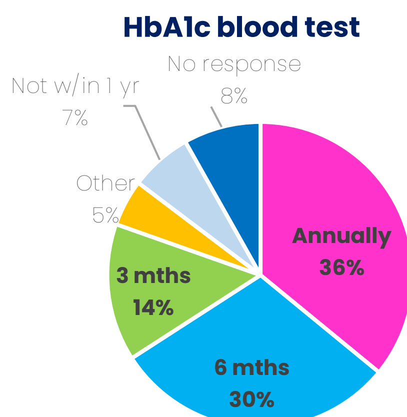
- An HbA1c test which checks average blood sugar levels over the last three months
- a cholesterol test to check blood fats
- blood and urine tests to check kidney function
- A blood pressure check
- A review of weight and BMI
- Eye screening to check for signs of diabetic retinopathy, a complication of diabetes
- A foot check to check nerves and circulation function
- A review and update of diabetes management plan.

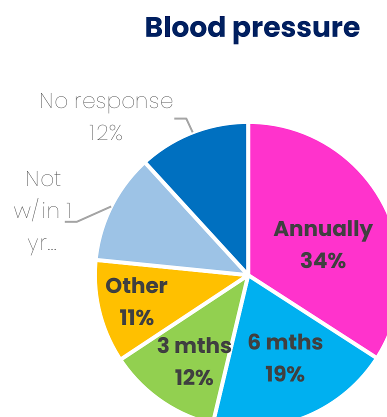
Receiving diabetes health checks

Project Questionnaire:

"How often do you receive diabetes related health checks to help manage your diabetes risks?"

551 responses





Key results to note:

Percentage of respondents who stated they had not had a diabetes health check within a year:

- 7% HbA1C blood test
- 12% Blood pressure
- 18% Weight
- 14% Cholesterol and kidney function tests *

* Patients answers to the questionnaire are based on their perception. It is possible cholesterol and kidney function blood tests may have been included alongside HbA1c blood tests. However some patients may not fully understand or be well informed about their blood test results.

'I thought I would be asked to come into the GP to see how my diabetes was, I didn't have any bloods done for a long time, I will have to chase it myself."

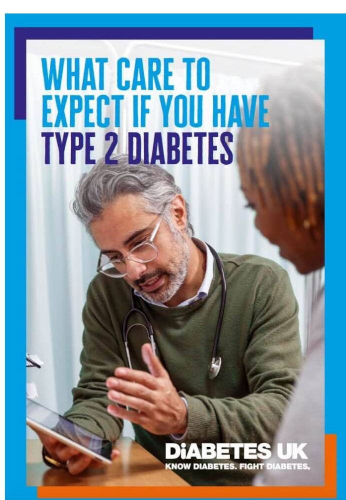
"Maybe telling someone new with diabetes to book into getting their bloods checked, as otherwise I feel that you are not checked by the GP."

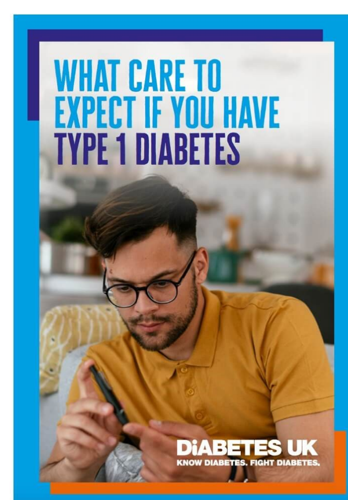
"Over the couple of years I have to tell my doctors I need a diabetic check-up as they never sent for me, and I was months overdue. I didn't get my feet checked for 2 years."

"Health professionals are trying to help - but some people don't help themselves"

Some diabetes patients may be booked in for their diabetes checks by health care services, others may have to make the appointment booking themselves - this process may be unclear for some diabetes patients. Healthwatch Sandwell have observed that some diabetes patients do not take the initiative to act to ensure they receive their annual diabetes health checks.

Diabetes UK booklets on "What care to expect" for different types of diabetes are a helpful checklist tool for diabetes patients.[40]





Recommendation:

Sandwell Health and Care Partnership ensure that all patients diagnosed with diabetes receive the Diabetes UK booklets on "What care to expect" and are clear about the annual diabetes health checks appointment booking procedures.

Recommendation:

BC ICB NHS health care service commissioners consider procedures to ensure all patients registered with diabetes are receiving the full range of diabetes checks.

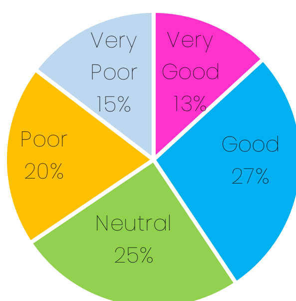
Patient experience of diabetes health care services

Project questionnaire:

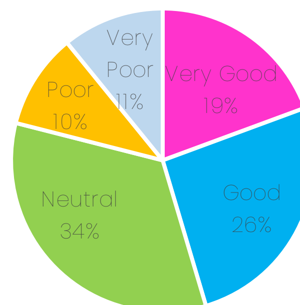
"Please rate your experience of any diabetes services relevant to you."

551 Responses

GP practice



Diabetes Clinic



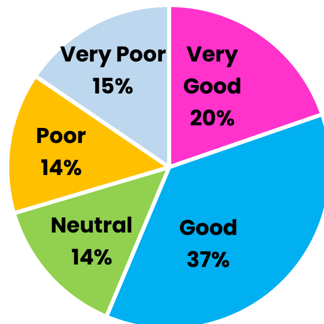
"Diabetes Clinic – seen every 2 weeks. I would be lost without them."

"I have received more help and guidance from the hospital diabetes team than my own GP Surgery, at least they try to help you."

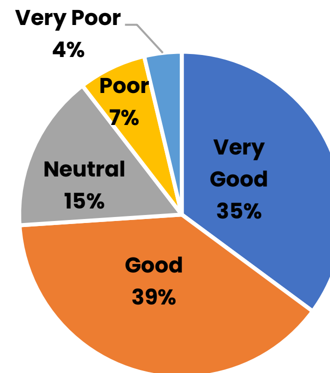
"Diabetes Clinic– very good and helpful. They listen."

HWS and YHP response results are shown seperately for the following sections due to notable variations.
551 Responses

Diabetes Nurse (HWS)



Diabetes Nurse (YHP)



"There is a lack of knowledge about diabetes with nurses at the GP than at the hospital."

"Nurse staff are good, but clinic is short, doesn't let people get to know their diagnosis."

"My Nurse C. Downing is very good and very supportive and is most helpful with my needs."

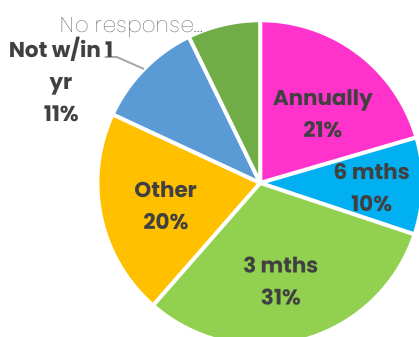
Podiatry

Foot care issues – patient with diabetes for over 10 years:

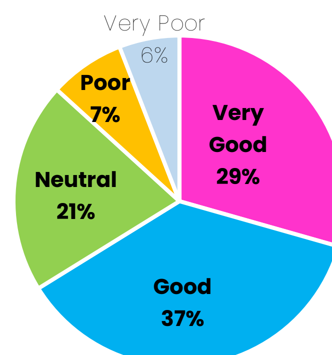
My diabetes management has been extremely poor to the point where I developed a foot ulcer recently which resulted in my left leg being amputated. Prior to this I had not received any advice or checks from any medical professionals for well over 12 months.

Since my amputation 5 weeks ago I am full of praise for the Diabetes Nurses who have spoken to me at length about my ongoing diabetes management and diet but service before this date I am sad to say was sorely lacking.

Podiatry checks (HWS)

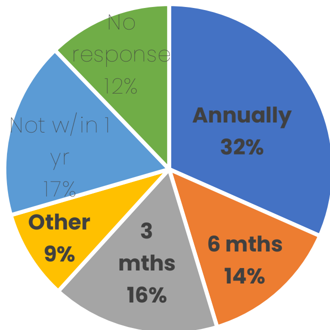


Podiatry service rating (HWS)

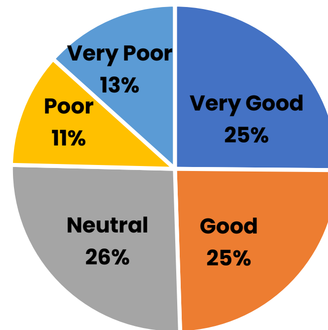


"I was referred to Podiatry by the Diabetes Nurse 7 months ago, still await an appointment."

Podiatry checks (YHP)

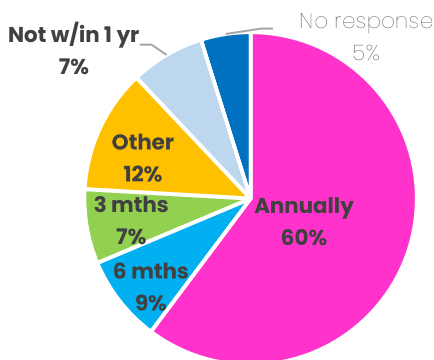


Podiatry service rating (YHP)

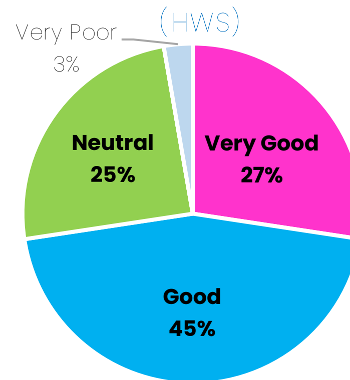


Ophthalmology

Ophthalmology checks (HWS)

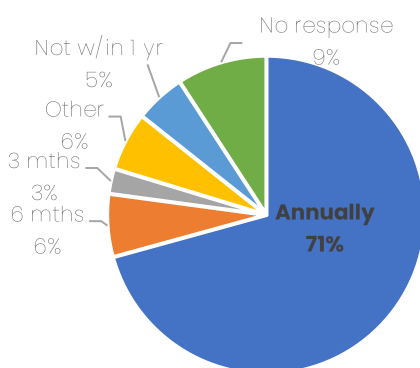


Ophthalmology service ratings (HWS)

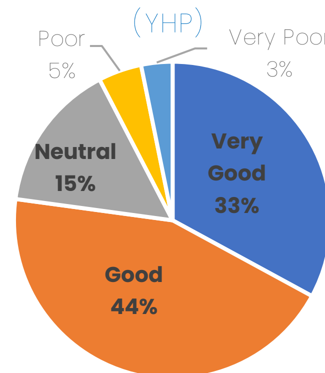


"Need improved appointment system for eye screening!"

Ophthalmology checks (YHP)



Ophthalmology service ratings (YHP)



Feedback received, including from members of Sandwell Visually Impaired:

"When services change their parameters patients should be consulted and involved in decision making and communicated with!"

"Some venues are over 4 miles away – it's 3 bus rides!"

"I told them I couldn't make my annual eye test as access was difficult – they said, 'don't bother then'!"

Patient feedback eye check services reduced:

Healthwatch Sandwell heard from quite a few patients, about changes to ophthalmology services for diabetic eye checks including the slit-lamp eye test for diabetic retinopathy.

Patients spoken with said they had not been consulted about the service changes. Main feedback related to reduced choice for appointment service and travel challenges especially as eye drops prevent driving for 4-6 hours after the appointment.

Healthwatch Sandwell undertook Enter and View of the NHS Diabetic Eye Screening service at Asda, Oldbury and established that there is a high demand of caseloads for the Diabetic Retinal Screener which can see up to 40 Patients per day (one every 5 minutes approximately).[41] Patients can amend the appointment venue choice but due to specialist equipment provision options are limited.

Recommendation:

BC ICB NHS health care service commissioners consider the patient feedback relating to diabetes health checks and identify opportunities for improvements to services, including a continuation of diabetes awareness raising and training within primary care services.

Self-management of diabetes - peoples experiences

Patient and health care relationship to support self-management of diabetes

Management, control and monitoring of diabetes requires a combined relationship approach between the person with diabetes and health care and support services, including ensuring annual diabetes health care checks and that the patient is well informed on diabetes management and associated health risks.

People with type 2 diabetes may be able to manage their condition and reduce related risks by:

- Understanding diabetes, management and health risks
- healthy eating
- regular exercise
- maintaining a healthy body weight

Support to help people understand and manage diabetes can include:

- Information and diabetes education courses
- Diabetes support groups
- Healthy eating and physical activity support offers

However, many people with type 2 diabetes, may also need to take medication by tablet or injection which may include insulin.

"Answers to questions as opposed to being "fobbed off" with oh you can look it up!"

"More help and guidance from GP surgery and to promote and discuss the opportunity to attend the diabetes X-pert classes, also to talk more about the issues with diabetic tech."

Self-management of diabetes – diet and physical activity

A person with diabetes is responsible for their personal diet and physical activity, which can help manage their diabetes condition and blood sugar levels.

"Diet can have an impact of around 30% on blood glucose levels."
(Head of Nursing - Your Health Partnership)

Physical activity can help an individual to further manage their diabetes levels and reduce impacts or risks of other associated health conditions.

"Doctors are too quick to prescribe medication when healthy changes can be made."

During engagement about the diabetes project Healthwatch Sandwell gathered the general picture that:

- many people have insufficient information to self-manage their diabetes condition well
- understanding of diabetes and the associated health risk factors is overall low
- there is a lack of supporting information and low understanding of nutrition and suitable diet
- there is an insufficient presence of diabetes support groups within Sandwell

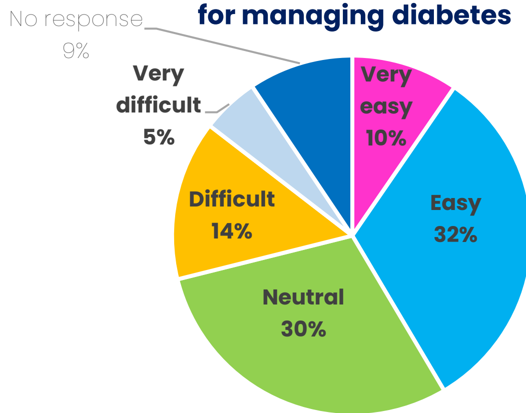
The next page questionnaire response results suggest that over 25% of Sandwell residents with diabetes may be finding aspects of management of their diabetes condition difficult or very difficult.

Project Questionnaire:

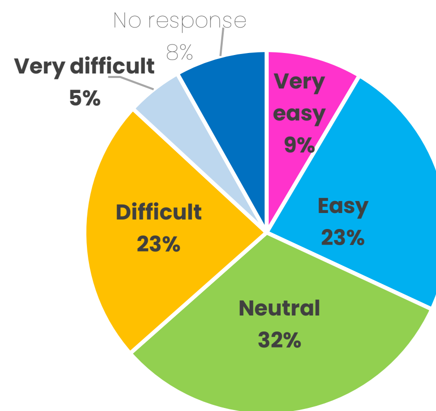
"Please rate your experiences of managing your health and wellbeing related to your diabetes."

564 responses

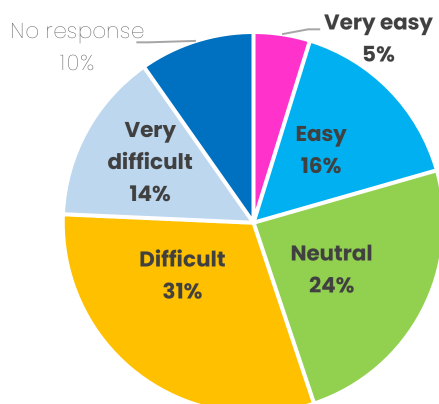
Understanding nutrition/healthy diet for managing diabetes



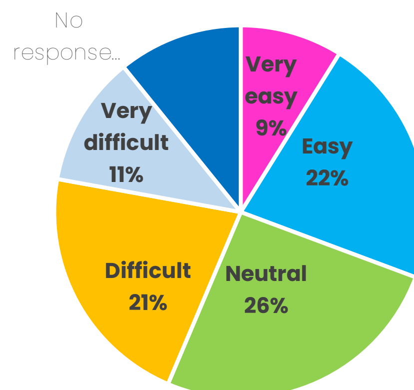
Maintaining a healthy balanced diet



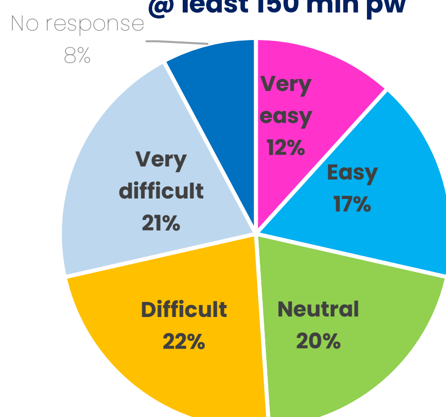
Maintaining a healthy weight



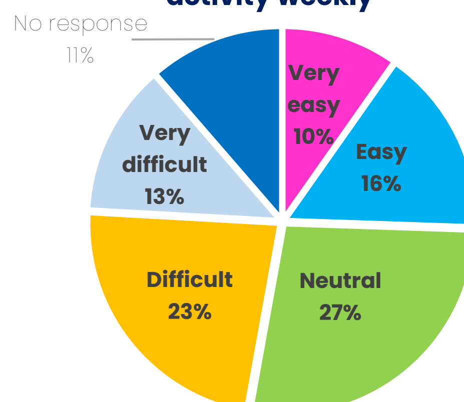
Maintaining mental wellbeing



Being physically active @ least 150 min pw



Finding spare time for physical activity weekly



"Diabetes is not the only thing wrong with a lot of people is it?"

Multiple health conditions – needing support to manage diabetes

Ms B is between 50- 64 years old, she has multiple long term health conditions including high blood pressure and has previously had a stroke.

Ms B stated that she found understanding nutrition and a healthy diet for managing diabetes **difficult** and maintaining a healthy balanced diet and healthy weight **very difficult**. Ms B stated it would be **easy** to find time for physical activity each week but finds being physically active **very difficult**.

Ms B stated she would like help with **"Exercise, weight loss and dietician."**

Project Questionnaire:

"What support services have worked well in helping manage health and wellbeing with diabetes?"

and

"What support services would you like to access or see improvements in for diabetes management and prevention? "

Information/education

Worked well:

"I watch TV programmes that teach about what to eat with diabetes."

Would like to see:

"Awareness clinics every now and then either in health centres in GP practices."

"More info about diabetes risks and effects on organs."

"Would be nice to be able to contact someone if necessary."

Support groups

Worked well:

"Peer support groups run at Dr Arora's pre covid was helpful (bring it back)."

"I was a member of a diabetes support group in West Bromwich, but it closed about 8 years ago."

"I attended a diabetes group in Tipton and found the lady who runs it to be very pleasant and helpful, she had time to sit with me and help with my emotions and just guided me. Well done to the lady."

Would like to see:

"A diabetes support group would be good similar to WW or Slimming World meet to swap recipes support each other get fit with each other etc."

"Peer support groups - talks on diabetes, sharing knowledge, lived experience, ideas, motivation."

"Potential social gatherings with both support services and other diabetic."

"I would like the surgery to provide sessions so I can get more help managing it."

"A drop in diabetic meeting. Not the same time every week as lots of people work shifts."

Recommendation:

Sandwell Health and Care Partnership consider the feedback on support groups and identify opportunities for increasing the offer across Sandwell, ensuring all support groups are adequately trained and supported with diabetes resources.

Nutrition/healthy eating

Worked well:

"Hospital nutritionist"

Would like to see:

"More nutritionists helping people to manage their diets and not just giving out leaflets."

"The government states eat healthy - but don't give tools to live by it and they allow promotion of foods that are unhealthy!"

"Refined sugar is an addictive substance – why is it not looked at as an addictive substance?"

"Fizzy drinks and take aways everywhere! Control is needed!"

Physical activity/weight management

Worked well:

"Portway Lifestyle Centre"

"Albion Foundation keep fit session."

"Free swimming for over 60's."

"Keep fit - YMCA."

Would like to see:

"Help with a weight loss program."

"Think more should be done to encourage people to lose weight and try to eliminate the disease, after all it only gets worse over the years needing more meds etc."

"There is nothing to do in my area - this affects taking exercise."

"I need more exercise classes locally."

"Free access to Health Centre for swimming and gym."

Mental wellbeing

Worked well:

"Sandwell Healthy Minds."

"Mental health council / Therapy."

Would like to see:

"Counselling"

"Easier access to talking therapies."

Recommendation:

Sandwell Health and Care Partnership consider feedback from patients on mental wellbeing within the report and identify opportunities for increasing the support offer at diabetes diagnosis and during patient self-management of the condition.

Focus Groups

Healthwatch Sandwell looked at patient experience for groups at higher risk of developing diabetes and possible issues or challenges with awareness of and management of diabetes. Conversations were held with individuals and in Focus Groups to gather insight on whether health, care and support services are meeting needs.

Healthwatch Sandwell gathered insight which may help inform and improve services. This section of the report includes insight and observations for the following groups.

- Older People
- Male population
- Gestational diabetes
- African Caribbean communities
- African communities
- South Asian communities

Older People

Diabetes UK has highlighted that more research is needed on the impacts of becoming elderly and managing diabetes. As people age some may become frail and have other health conditions including having an increased risk of vascular dementia with diabetes.[4]

Healthwatch Sandwell explored experiences of aging and managing diabetes through Focus Group conversations including through several visits to St Albans day care services.[42] The insight gathered helped highlight that issues and challenges with managing diabetes were more likely to be present as people became elderly and possibly frail - the report focuses on these aspects.

Reduced mobility/weight bearing

- impact on being able to be physically active, diet control
- independence and mental well-being may be affected
- impact on ability to shop and prepare food, transport needs

"I have no balance so need chair based exercise"

"Exercise options when restricted by hip condition."

"It is hard to keep a healthy weight with my arthritis."

"My husband has mobility issues - taxis to all his health appointments are expensive!"

Frailty/care support needs

- Memory problems - may affect taking medications, arranging and attending appointments
- Carers (professional or family) – need understanding of diabetes and managing the impacts.

"Care staff understanding diabetes management is important, some don't read the care plan - timing of visit is important for managing diabetes."

"My son supports me with my diet to reduce sugar and salt intake. This has made a big difference this year and helped me lose weight. He has actively sought information on diabetes to support me."

Elderly frail couple – experiences of managing diabetes:

Ms & Mrs C are in their mid-80's, both have diabetes. They talked about their experiences of managing their diabetes as they have aged:

Mr & Mrs C's family support them with appointments, transport and cooking.

Pre Covid Mrs C was having swimming lessons and walking in the local park. Covid restrictions practically prevented these activities and Mrs C's mobility has declined, she now uses a walking frame and stair lift. Mrs C's metformin medication for controlling her type 2 diabetes has increased and she now has insulin injections too.

Mr C has had type 1 diabetes for over 20 years, his eyesight is failing, and he has had some falls. Mr C has been hospitalised with complications with managing his diabetes, he feels the home care visits help with managing his diabetes.

Support with health conditions

Mr A had a stroke a few years ago and was prescribed slow release tablets for his diabetes.

"It's the best thing that happened, my diabetes doesn't go up and down so much now."

"The stroke support gym sessions at West Bromwich Albion are great! 3 hours activity and gives me a break as wife and carer."

"They think everybody is computer literate, I haven't got a computer"

"It would be good if they put information in the Sandwell Herald."

"Link in diabetes services with local social clubs for older people."

Recommendation:

Sandwell Health and Care Partnership consider the findings relating to elderly people and potential impacts on management of diabetes identifying any possible improvements to care and support services for patients and family carers.

Male population

Several Focus Group conversations highlighted, in some male participants, levels of denial of diabetes and resistance to lifestyle changes to help manage the condition and associated health risks.

"I have been diabetic for a while. I have been given advice, but I like my food and I am not changing. Sometimes the diabetes is up and down."

"I did not take any notice when diagnosed with diabetes in my 20's, I am in my 60's now. Health services have been good, but I haven't helped myself, I am blind now. I wish I had listened to them!"

Diet management

Mr A, a long term diabetic, who had a stroke a few years ago said:

"I took no notice when I was diagnosed. I have the occasional cake, it doesn't hurt you, it won't kill you!"

Mr A's wife added **"You can forget when you have already had some cake, I have to remind you."**

Request for support

An Asian man in his 50's with diabetes and multiple health conditions including visual impairment asked Healthwatch Sandwell for more information about exercise groups.

A referral was made to Healthy Sandwell.

Managing social life

One man shared with Healthwatch Sandwell about supporting his local football club. He spoke of managing his diabetes by alternating social drinks over weekend fixture matches by beers on one day and lime and soda on the other.

He also shared concerns about a male friend with diabetes and high blood glucose levels who drinks 6 pints a day.

"There is peer pressure to drink alcohol, they think just take your meds and you will be fine!"

Healthwatch Oxfordshire - Men's Health Report

Healthwatch Oxfordshire worked with a local football club, East Oxford United, to successfully engage with men about health.[43] Their report made an observation:

Men face barriers to accessing health care due to time and constraints due to shift work, long working hours and unpredictable working patterns. This has an impact on ability to take care of themselves as well as taking up on NHS Health Checks.

Recommendation:

Sandwell Health and Care Partnership consider the insights relating to men managing diabetes and identify opportunities for targeted engagement and support for diabetes management.

Gestational diabetes

Gestational diabetes can present risk of complications during the pregnancy and increases the risk of developing type 2 diabetes post pregnancy. Healthwatch Sandwell gathered some insight by asking about gestational diabetes in the project questionnaire, however, a Focus Group conversation did not occur.

6 women responded to the project questionnaire referencing gestational diabetes, **2** currently during pregnancy and **4** who were post pregnancy.

3 of the women had not been given or signposted to information about diabetes risks post pregnancy, **2** had received information from the GP practice and **1** did not respond.

"Was told to research information on internet. Information was all in English hard to understand it all."

2 women indicated they had subsequently developed pre-diabetes and accessed supporting information.

3 of the women stated thyroid health conditions. **5** were receiving annual HbA1C blood tests.

"My sister has thyroid problems, now I do too, plus pre-diabetes – I wonder if things are connected?"

Patient experience of management of gestational diabetes

An Asian woman in her mid-20's shared her experiences with Healthwatch Sandwell:

"Information was limited and wrong. There seems to be a set pathway for women with gestational diabetes, to be put on medication and induced. I wanted to be the healthiest mum I could be and give my baby the best start."

"I had to learn about the best things to eat like why blood sugar could be higher in the morning and pairing fruit with healthy fats. I found the Gestational Diabetes UK website very helpful, and it even has lots of recipes."[44]

"I was able to get it under control which gave more options regarding birth."

"I had to do that myself. I was referred to a dietician, but I didn't get seen until 34 weeks and I had already made the changes myself. They just told me to carry on with the changes I had made."

"Now, I do not have diabetes, but I am still careful of the foods I eat."

Recommendation:

Sandwell Health and Care Partnership consider the initial findings in this report and plan to engage with patients during and post gestational diabetes to help inform and improve services and patient diabetes risk awareness and management.

Ethnic communities

People from Black African, African Caribbean and South Asian (Indian, Pakistani, Bangladeshi) backgrounds are at a higher risk of developing type 2 diabetes from a younger age, for South Asian ethnicity also at a lower BMI.[5]

"Diabetes blood tests for ethnic groups at higher risk should be done earlier."

Healthwatch Sandwell explored patient experiences and cultural differences with individuals and local groups to help inform the project findings. The information is presented for each ethnic group in the next section.

However common to all groups is a need for improvements in:

- Information and education courses - to be culturally relatable, including imagery and dietary information, and provided in accessible formats to meet individual needs

- Support and development of physical activities that may appeal to ethnic groups and increase uptake to help manage diabetes.

African Caribbean

Healthwatch Sandwell and Sandwell African Caribbean Mental Health Foundation worked together on a Focus Group conversation event about diabetes in African Caribbean communities.[45] An Information Resource was produced highlighting key findings the group and individual conversations:[46]

The main insights to highlight from the Focus Group work were:

- Community awareness and understanding of diabetes and risks is low
- Information on diabetes – shortage of culturally relatable images and dietary information
- Some resistance to attending GP practices (despite higher risk of diabetes at an earlier age)
- Beliefs, cultural values, emotional attachments to traditional African Caribbean foods – distrust of processed foods and food additives
- Apparent lower uptake of physical activities, weather an issue, options less appealing
- A call for support to African Caribbean communities to enable raising awareness and education about diabetes and risks starting at teenage level. (Diabetes Community Champion training)

"I have been told I am pre-diabetic, but I don't know what this means – I am confused!"

"Should not wait till ready to fall over before running to the Doctors!"

"Less motivation to be active in the UK – people don't feel like going out if the weather is bad"

The group had conversations about teaching young people cooking skills, inspiring, perhaps through famous Black chefs, a love of cooking and eating nutritious foods.

African

Healthwatch Sandwell and Diabetes UK joined a NHS health check event at Ileys Community Centre[47] to provide information and raise awareness of diabetes and risks with a group of people from the Somalian community. Individual conversations were held with some of the group participants who were seeking more information and support. Diabetes UK also visited newcomers to Sandwell in a hostel for asylum seekers.

Observations to note include:

- Diabetes is sometimes not a recognised term but the concept "sugar" in the blood might be
- Possible language barriers and lack of reading skills as education may have been oral learning
- Relatable images and simple information is best, videos or demonstrations can help
- Interpreter services may be required – partnership working with voluntary community organisations

South Asian

Healthwatch Sandwell spoke with individual Sandwell residents and worked with Diabetes UK, Healthy Sandwell and voluntary and community support organisations to gather insight on diabetes within South Asian communities.

Diabetes UK state that people of Indian, Bangladeshi and Pakistani ethnicity store visceral fat differently, affecting insulin levels and increasing risks of developing type 2 diabetes. People of other South Asian ethnicities may also be affected but there is insufficient research to date.[48]

The collective term **South Asian** covers many different ethnic and cultural groups, diets and traditions vary.

It is important to recognise the insight shared is generalised and relevant to some groups and individuals. But supporting diabetes management requires a **personalised approach to address individual needs.**

Awareness of diabetes

Low awareness of increased ethnicity risk levels for diabetes or understanding of diabetes, associated health risks and how to manage the condition.

Information اُردُو

Language or reading skills may be a barrier to understanding information about diabetes. Information provided at diagnosis, or referral to education courses, by health care services may not be in an appropriate language, format or tailored to a patient's ethnicity or cultural values.

"No interpreter at my GP practice to explain diabetes – I felt rushed through."

Word of mouth, audio or video formats may work better for some people. Images/simple wording is best.

Diabetes UK continue to develop their range of resources for other ethnic groups, including in other language options.[49] Diabetes UK also produce useful information resources to support cultural celebrations such as fasting during Ramadan.[50]

Education courses

Healthwatch Sandwell noted that there appears to be insufficient referral and uptake of courses educating on diabetes and management. Feedback received included that generally courses are not tailored to reflect and resonate with cultural aspects or personalised.

The Confederation of Bangladeshi Organisations[51] had previously hosted a 12 week diabetes course at a community centre. The Bangladeshi women spoken with asked for more tailored diabetes training to be offered to them as a community group.

Local organisation Desi Diabetes[52] provides courses focused on South Asian culture including in Punjabi. Resources are available including books in other languages and educational videos in Punjabi.[53]

"Diabetes information in video and more of these local classes would help."

"Desi Diabetes very good at giving information in Indian languages, makes it easy to understand."

Health care and support services

Healthwatch Sandwell heard that some people tend to have faith in and rely on professionals, rather than being actively involved as patients, in any decision making about their treatment.

"We are grateful for the NHS, we don't want to be an extra burden, we want support."

Self-management of diabetes

Healthwatch Sandwell observed some lack of recognition of the concept of self-management of diabetes, such as food or exercise choices and the ability to reduce impacts and health risks.

"It's inevitable." **"It's Allah's will."**

Food

Sharing food is part of the culture. A traditional meal may be high in a range of carbohydrates, white rice can be a staple of several meals a day. Affording a wide range of healthy food options may be a challenge in some households. South Asian traditional celebrations may include sweet treats. Refusal of foods offered could be seen to cause offence. Younger generation members may access more western diets including convenience foods.

"Rice is standard with most meals, including breakfast and pudding, sometimes included in bread too. Ripe mangoes are a favourite, they remind of homelands. There is an emotional attachment to certain traditional foods, especially in older generations who migrated to the UK."

Family values

Many South Asian families may live as a multi-generational household. Healthwatch Sandwell heard that some families tend to eat late in the evening due to the impact of employment work shift patterns. Carbohydrate heavy meals eaten late at night could contribute to weight gain.

Healthwatch Sandwell also heard that family responsibilities may have an impact on free time for physical activity or financial decision making. Also that family members may **"suffer in silence"** rather than be open about health or wellbeing concerns.

Diabetes UK research on reaching South Asian communities states:

Key to achieving an attitudinal shift within the South Asian community is to get conversations started within families, across generations, so that those living with diabetes open up about what it's like and talk to their children or grandchildren – who are at increased risk due to family history. In this way, these younger family members will become aware of the seriousness of the condition and take steps to prevent it.

Physical activity

Birmingham City Council Public Health presented findings stating that South Asian people are overall less physically active than other ethnic groups, this being especially the case with Bangladeshi and Pakistani women.

Healthwatch Sandwell received feedback and requests for more support for women only physical activities including women only swimming group opportunities, and assurance of **"female only lifeguards."**

Recommendation:

Sandwell Health and Care Partnership consider the findings in this report relating to ethnic communities at higher risk of diabetes and develop a collaborative action plan for improvements in diabetes health, care and support services offers, including targeted diabetes awareness raising, information provision and risk screening.

Developing a partnership approach to diabetes services

Patient Feedback - Take a holistic view of a person's needs:

An individual assessment that takes into account physical, mental & total overall view of a person's lifestyle & their individual needs including their dietary requirements. I feel it's so easy to 'categorise' an individual & blame diabetes on genetics, but I feel a detailed & thorough assessment whereby a professional should try to find an area where improvements can be sought & help should be offered straight away.

Example, I have limited mobility = not enough exercise = the change from pre to now diabetic.

"What help is available for me where I can burn calories or maintain healthy cardio scores?"

Information and education courses raising awareness of diabetes risks and supporting self-management of diabetes are the foundations for enabling and empowering individuals and communities, increasing diabetes prevention and reducing diabetes health risks.

There are a range of initiatives and service offers available across Sandwell communities supporting physical activity, weight management and to some extent healthy eating and mental wellbeing related to diabetes management. Sandwell residents with pre-diabetes or diabetes can be referred or signposted to such local support.

However, there are opportunities for improving diabetes awareness, information and education and for practically supporting development of diabetes management support within communities, especially within ethnic communities. Diabetes UK - Diabetes Community Champion training programme includes training representatives within voluntary organisation and community settings.[54]

Services and resources are mainly already in place. An integrated health, care and support partnership approach could help connect service offers and improve outcomes for more people living with and managing diabetes and better meet needs of the diverse population of Sandwell.

An Integrated Health, Care and Support Partnership approach to managing and reducing diabetes in Sandwell could include:

- NHS (primary care and diabetes specialist services)
- Sandwell Council – Public Health
- Sandwell Council - Healthy Sandwell
- Diabetes UK
- Voluntary Community Sector Organisations
- Healthwatch Sandwell

Partnership working could enable a personalised holistic offer to Sandwell residents around diabetes awareness, prevention and management and could include:

- diabetes information – (ensure range meets individual needs)
- diabetes education - (ensure range of offer meets individual needs)
- Diabetes UK helpline
- diabetes information and support drop-ins / pop ups / "roadshows"
- diabetes community outreach (target health inequalities e.g. ethnic communities)
- community health check programmes e.g. Sandwell free health checks for 40 - 70 year olds
- signposting to support, including community programmes for diabetes management, ensuring a holistic service offer
- developing targeted physical activity options e.g. diabetes peer support groups / options with more appeal to ethnic community groups
- enabling community support groups
- community support programmes (e.g. cooking classes, exercise groups, family support)
- tailored support meeting specific needs e.g. ethnic cultural focus or impaired mobility due to disabilities/long term conditions/age related impacts
- Diabetes Community Champion training programme

Recommendation:

Sandwell Health and Care Partnership enable and empower local communities at "grass roots" level on awareness raising of diabetes prevention and risk management and practically support initiatives for living healthily with diabetes.

Recommendation:

BC ICB service commissioners explore opportunities for development of a Diabetes Community Champion programme delivered through Diabetes UK, identifying target communities and delivery partners with Sandwell Health and Care Partnership.

Recommendation:

Sandwell Health and Wellbeing Board consider the diabetes report findings and with Sandwell Health and Care Partnership identify a partnership approach to developing improvements to diabetes services and holistic support for Sandwell residents and communities in managing the condition and risks.

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