NHS
Greater Manchester

Appendix 1

Structured Diabetes Education

Engagement Report

May 2025

Contents

Structured Diabetes Education Engagement Report.... **Error! Bookmark not defined.**

Version control .... **Error! Bookmark not defined.**

Contents 1

Section 1: Introduction and overview..2

Who answered our survey...9

Section 2: Experience of current service 12

Patient and public view..12

Professional view 15

Section 3: What should an improved education offer look like?..........17

Patient and public view..17

Professional View..26

Section 4: Health inequalities 28

Inequalities 28

Section 5: Key points to consider and next steps 30

Key points for commissioners to consider 30

Next steps 30

Section 6: Glossary and accessibility 32

Glossary...32

Accessibility and translations...34

Section 7: Appendices 35

Appendix 1: Survey equality monitoring data...................................35

Section 1: Introduction and overview

On average people with type 2 diabetes will see a healthcare professional for 3 hours a year.

For the other 8,757 hours they are left to manage their condition on their own. It is therefore important that people living with diabetes understand how to manage their condition themselves.

Research suggests that Structured Diabetes Education (SDE) can improve the outcomes for people, these include:

Reduced HbA1c levels (average blood sugar levels)

- Reduced the number of times people experience hypoglycaemia (periods of extremely low blood sugar levels)
- Reduced the number of times people experience hyperglycaemia (periods of extremely high blood sugar levels)
- Preventing common complications from diabetes and improving quality of life.

Structured diabetes education is a short course of usually face-to-face (sometimes online) sessions offered to those newly diagnosed with type 2 diabetes or those wanting to increase their knowledge about managing their condition. Group education is the preferred delivery method as people often learn better in face-to-face interactive sessions. This said, online or digital programmes are also available for those who prefer to learn this way.

A recent review of SDE services across GM found several issues, meaning this is not meeting the needs of people living with type 2 diabetes.

The review found:

- How the services are commissioned (managed and overseen) is unclear
- Poor referral mechanisms and service provision
- Take up of those offered education is low

- Unnecessary differences in access across Greater Manchester localities
- Data recording of who has and not attended is poor
- Refresher courses are only available in 1 of the 10 Greater Manchester localities
- Poor outcomes for people living with type 2 diabetes.

NHS Greater Manchester (NHS GM) launched 6 weeks of public engagement on 6th January 2025 to ask people living with type 2 diabetes, as well as family, friends, carers and health professionals, for their views on how they would like to get information and support to help manage their condition and exploring how we can improve structured education for type 2 diabetes patients from across Greater Manchester.

A broad and robust communications campaign was carried out, targeting key stakeholders and communities through an online survey available in the 10 languages spoken by the target communities, social media campaigns, including an animation and a GP call to action video, 2000+ postcards distributed to GP surgeries, gateway centres, and other public venues, and printed advertisements in local, free newspapers. In total, we engaged with over 400 people.

There was a targeted outreach approach on reaching groups who are underrepresented in SDE, specifically:

- South Asian communities
- Black African Caribbean communities
- People with learning disabilities.

This report sets out what we have learnt from the engagement and the key themes people shared with us.

The number of responses was lower than anticipated however those that did respond were very clear about what should be within the offer. For the full details of who took part, please see the appendices.

The report will be used to further shape the proposals for improving a SDE offer to those newly diagnosed with type 2 diabetes and those needing a refresher course. We will share updates on our website so people can follow what has changed because of the engagement, particularly around the recommendations.

Our thanks go to all our colleagues and partners who have supported us to reach and involve people. Our even greater thanks go to all those who took the time and trouble to engage with us and share their experiences, thoughts, and ideas – we are very grateful.

This report will be published on our website and shared widely. If you would like it in a different format or language, would like a printed copy, or have any questions, if you would like to be kept up-to-date, or get involved in the next steps, please contact us:gmhscp.engagement@nhs.net or 07786 673762.

Image 1: Afro Fit, Gorton, Manchester

Key themes summary

This is a summary of the recommendations to improve the structured diabetes education offer across Greater Manchester:

- Structured diabetes education is welcomed to help those living with type 2 diabetes understand their condition and manage it effectively
- More awareness is required to promote what is on offer
- The referral process needs to be improved to be more inclusive
- More accessible courses are key to increasing attendance and participation
- Bespoke courses are required, for certain communities at higher risk of developing type 2 diabetes
- Session facilitators should represent audiences, where possible
- A varied offer of both online and face-to-face sessions would be beneficial
- Education sessions should be hosted in community settings, with established groups
- Dietary information needs to be specific to the audience and sensitive to different cultural practices and beliefs
- Refresher course would be beneficial at different intervals
- The referral pathway and communication between professionals and providers needs to improve, to ensure the patients access timely education sessions.

How we engaged

Online survey

A total of 222 people completed the survey. This was a combination of online entries and printed surveys, completed at community involvement events across Greater Manchester. The details of those who responded is on the next page. It was acknowledged that the number of responses was lower than we would have wished, despite additional attempts to widen engagement by paid advertising and social media posts and other promotion activities.

Focus Groups

There was a total of 135 who participated and contributed to discussions, including those with lived experience of using SDE, as well as those who provide a supportive role.

We delivered targeted focus groups to generate more detailed intelligence with those communities who are at greater risk of developing type 2 diabetes as identified through the Equality Assessment and who may require additional communication needs.

A total of 7 focus groups were held with representation from the following communities:

- 2 x South Asian Community
- 2 x Black African Caribbean community
- 3 x People with learning disabilities.

In addition, we arranged and promoted face-to-face and online focus groups, however due to very low interest, we cancelled the sessions and instead offered one-to-one calls – 2 people took up the offer and shared their experiences.

Locality Engagement

Information and materials were distributed to various key stakeholders, including some GP practices and housing teams, with a presentation being shared with representatives from health and care partners from across Greater Manchester.

Conversations took place at various community events and literature was also distributed to diabetes clinics across each locality and in public buildings places where lots of people go.

Engagement assets

A full range of engagement tools and resources were developed, which included:

- Online survey (translatable to 10 languages)
- Social media campaign (including paid, targeted social media)
- GP clinical lead call to action film
- Animated film
- Printed information postcards (2000)
- Digital and printed posters
- Printed advertisements in newspapers.

Accessible information produced included:

- BSL explainer film
- Animated explainer film in Urdu, Punjabi
- Printed survey
- Easy read information and survey
- Printed survey in 3 languages (Punjabi, Gujarati, Bengali) and online survey in 10 languages

Communication channels

All the following channels of communication were used to promote the engagement:

- NHS GM Stakeholder bulletin article
- NHS GM Primary Care bulletin article

- NHS GM Staff bulletin (Keep Connected) article
- GM Provider bulletin article
- GM Moving Newsletter article
- NHS GM webpage article
- NHS GM/engagement team stakeholder mail out
- SCN diabetes and Long-Term Conditions stakeholder mail out.

NHS Greater Manchester website

During the engagement period, there were over 3,000 clicks on the engagement page.

Of this, 2,108 individuals visited the survey page directly, which means all either used the QR code contained on engagement resources or clicked on the survey link directly, located with stakeholder emails.

This equates for 72% of all respondents.

Social media

During the engagement period, a total of 22 social media posts were shared over our various platforms. A total of 14,417 people viewed these messages. A breakdown can be viewed below.

Organic posts

- 9 organic posts on our Instagram account with a combined impression or reach of 740
- 7 organic posts on our GM Integrated Care Partnership (GM ICP) Facebook page with a combined impression or reach of 1,999
- 2 organic posts on NHS GM LinkedIn page with a combined impression or reach of 797
- 1 organic post on GM ICP X account with 254 views.

Paid for posts.

- 2 paid for advertising posts on our GM ICP Facebook page with a combined impression or reach of 9,515

- 1 paid for advertising post on our GM ICP Instagram account with a combined impression or reach of 4,902.

A total of 132 individuals were directed to the survey directly from interacting with these social media posts.

Who answered our survey

It is important that we understand who completed our survey.

Most of the individuals who completed the survey chose not to complete the equality monitoring questions, therefore this report does not give an accurate picture of the reach according to demographics or diversity.

What we do know is that over three quarters of all the online respondents (222 people) had a type 2 diabetes diagnosis, of which nearly all were diagnosed over 12 months ago. This means that most respondents were from the primary cohort we were hoping to hear from.

We also know that just over a fifth of responses came from professionals responsible for delivering diabetes services, therefore suggesting there was a strong appetite to help improve educational resources and support services.

We also heard the voices of a small number of people who had been diagnosed with pre-diabetes, who wish to ensure that should they later be diagnosed with type 2 diabetes, that any education service meets their needs.

A few responses came from interested members of the public as well as other preventative roles, such as health and wellbeing coaches.

This indicates a diverse range of stakeholders who demonstrated an interest in SDE.

Partnership work

To enable us to reach as many people as possible to have their say, we reached out to numerous stakeholders and organisations. We provided information in numerous ways including a stakeholder pack to assist organisations to deliver their own group sessions and one to one conversation. Although, to date we haven’t receive any insight from any organisations, we are aware that some used the information and signposted their users to the online survey.

We’re awaiting a report from Oldham Healthwatch, following a similar piece of diabetes engagement they carried out with people with learning disabilities, but this wasn’t available when writing this report. This report will be important additional context for delivering sessions to people with learning disabilities.

See the next page for some of the stakeholders we worked with. This is not an exhaustive list but demonstrates the variety of partners whom we engaged and collaborated with on this project.

Image 2: A pop-up stall at Khizra Mosque, Manchester

Yellow Bird Group

African Caribbean Care Group

Sugar Group

GM LGBTQ+ Ambassador

Europia

Chit And Chat Group

GM Moving

Kashmiri Project

Listening To People Group

Afro Fit

Alchemy Arts

Yemini Association

The Life Centre

Khizra Mosque

Healthwatch Oldham

Action Together

Pennine Mencap

Stretford Public Hall

Section 2: Experience of current service

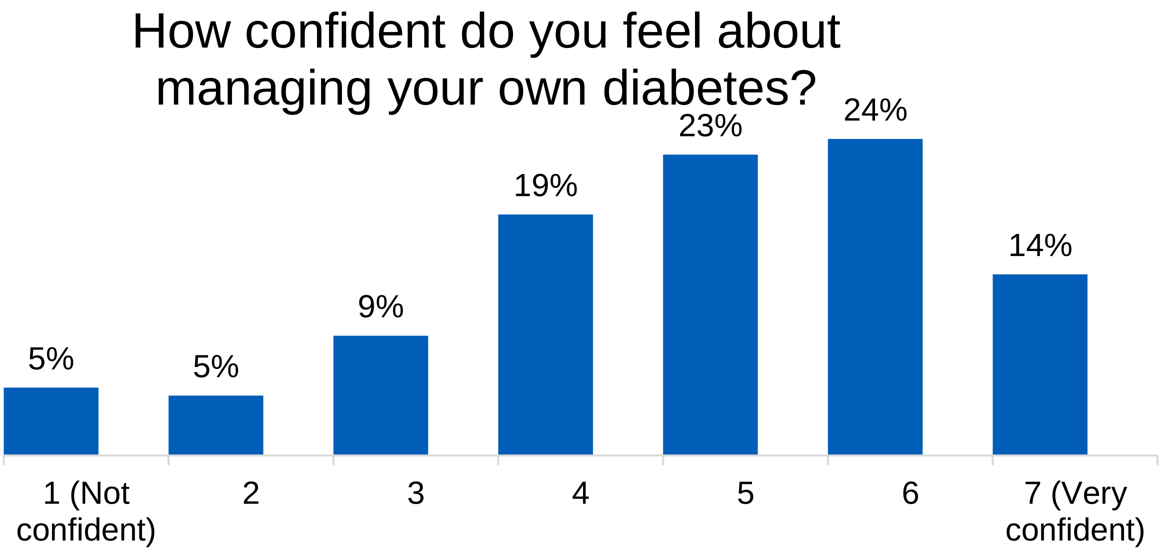
Lived experience is key to highlighting the reality of a service. The varied engagement activity which took place during the 6-week period generated feedback based on real experiences. Throughout the survey questions, focus group, and one-to-one discussion, the feedback provides ideas and suggestions about how to improve the current education offer, as well as the content covered with specific considerations which might be required when providing a service for all those newly diagnosed with type 2 diabetes.

Patient and public view

The following information is a summary of the responses in relation to how patients, public and professionals are finding the current service in relation to the offer of education to manage type 2 diabetes.

We asked people how confident they felt in managing their diabetes, and how they supported themselves.

Chart 1: Confidence in managing diabetes



As you can see, most people are only somewhat confident in managing their diabetes.

People who are currently diagnosed as pre-diabetic are slightly more likely to feel more confident about their ability to manage their diabetes, should they develop diabetes.

Whilst there were people who described reading “every book ever written” about diabetes, only 10 people felt that they currently have enough information to manage their condition.

When looking for help, most people rely on appointments with their nurse or doctor to get information to support them. Only a quarter of people used online information, with the most used website being Diabetes UK.

A few individuals expressed scepticism towards conventional medical advice, preferring to conduct their own research.

This demonstrates that there is a need for further support and education for people living with diabetes.

> *“It would have helped me realise I don’t look after myself”*
> Person with diabetes

Experiences of the current offer

Over 40% (4 in every 10) of those who engaged with us had been invited to attend type 2 diabetes education when they were diagnosed. They were nearly all referred by the GP practice – either directly by their GP or practice nurse.

Approximately 60% (6 in every 10) of these people attended at least some of the sessions, with most people attending the whole course. The same number of people said they would have attended if they had been invited.

Of the 60% of people who attended the course, a quarter (1 in every 4) of respondents found the course helpful.

Respondents generally found the course to be informative and useful, particularly praising the content and presentation. Those newly diagnosed appreciated specifically the diet information and lifestyle information. The take-away literature was considered helpful by some, who referred to it over time.

Many gained new knowledge and found it engaging. The information they received was generally felt as being relevant. However, some people felt it was a lot to take in and a couple of others found it too basic and broadly generic.

Some would have valued a more tailored approach, with a suggestion for a quick check before attending, to assess what knowledge people need. People also suggested a relatively quick follow up, to ascertain if anything had been missed or how they could find this information independently.

We expected that location would come up as a reason that people didn't attend. Some individuals from South Asian Communities and those with learning disabilities identified that they felt apprehensive about attending settings they were unfamiliar with.

However, for those who were invited but didn't attend, the most common reasons that they didn't go were:

- They couldn't make the dates
- It didn't fit around work or caring responsibilities
- They were too anxious or nervous – some people mentioned feeling embarrassed and self-conscious.

Two people highlighted that the course didn't meet their access needs, for example, the course was upstairs and there wasn't a lift.

When people who didn't know about the course were asked if they might have attended if invited, those who were unsure were more likely to be concerned about the location, and the timing, with it needing to be convenient for them and accessible for people using public transport or with low mobility.

This was the view of many from the South Asian community and those with learning disabilities, citing that many required assistance or support from carers and family members and that attendance would depend on whether someone could accompany them. This was especially apparent for those who had bought in care with evenings and weekends being identified as being particularly difficult to attend training.

People also shared with us how they received information to manage their diabetes. There was lots of variation in this, with a quarter of people (1 in 4) getting their information at their annual diabetes check with a further one in five receiving information from appointments with their GP/Practice nurse as and when they needed it.

A further quarter got their information online including from support apps. The most popular source of information was Diabetes UK's website.

> *"The advice is always very generic. There are too many people with differing needs and opinions, as an introvert I tend to switch off and disengage"*
>
> A person with diabetes

Professional view

Only a small number of respondents to the survey said they were professionals or worked in the field.

Of these, just over 60% knew about the structured education offer for those newly diagnosed and were able to make referrals.

There was a mixed response regarding knowledge and experience of the referral pathway into SDE education, but many respondents stated that they found the process easy or very easy to follow.

Some suggest the process to be more complex than necessary and advocated for integration with GP practices for more personalised education.

For a few, they reported referral difficulties, citing services being unavailable with course waiting times varying in each area, with Oldham viewed as an easy process whilst Tameside professionals reporting experiencing lengthier waits times for people to start the programme.

The most frequently mentioned diabetes education programme which professionals referred into was DESMOND. Diabetes My Way was also mentioned several times.

Section 3: What should an improved education offer look like?

This section will look at the suggestions people made to would improve the offer of type 2 diabetes education and make it easier for them to engage with it.

Patient and public view

Advice and support

There were 89% of respondents who shared views on how they would prefer to access advice and support. Just over a quarter thought this would be best through an app or website on their phone or computer. Just under a quarter of respondents said they would prefer a group in person where they could go and meet with an expert and other people with diabetes. With this just over a fifth said they would just like somewhere to drop in and ask questions when they needed to.

Respondents expressed a strong preference for personalised and flexible access to diabetes advice and support when they needed it. Respondents wanted consultations with experts as they felt that current conversations with healthcare professionals were rushed. Some respondents prefer a variety of different ways to receive knowledge, ranging from information available in a community setting, peer-to-peer support groups and online resources. A few people said they'd like to receive printed literature, through postal communication. When asked during the focus group there was an overwhelming response for tailored face-to-face courses within a culturally appropriate or support group setting.

Additional comments frequently mentioned written information as a key method for gaining knowledge and increasing confidence in managing their diabetes, highlighting the importance of online resources, provided by a variety of healthcare services.

Just over 80% of respondents to the survey said that support should be offered within 1 to 4 weeks after diagnosis.

> *"Attending sessions would increase my knowledge and educate me more so I can control my diabetes in the best way possible. Improving my quality of life"*
>
> A person with diabetes

Structured education course

The survey results show that the majority (nearly 80%) of respondents had been diagnosed with type 2 diabetes, with just under half of these not being invited to any diabetes education session. This feedback is also significantly reflected from those who attended the focus groups.

Respondents were clear that if they had known about the offer of education, they would have welcomed this, as suitable information was essential to help manage their condition.

This would strongly indicate there could be improvements made to the referral process and ensuring that patients aware of the offer of diabetes education.

> *"I was recently diagnosed, I had no idea what diabetes was, I was desperate for information but didn't really get it"*
>
> Chit and Chat member

Course content

People were clear that they wanted the support without it being patronising, preachy or stigmatising.

The top four areas of information people said they would find useful to manage their condition better was evenly split between:

- Advice on a healthy diet and what you can/can't eat with diabetes

- Advice on the complications of diabetes and what to look out for
- Advice on how manage your weight
- Information on what your diabetes diagnosis means for you and your lifestyle.

There is a notable interest in understanding the impact of carbohydrates and other foods on blood glucose levels, as it was perceived that only sweet and fatty foods were responsible for poor health management. This was particularly relevant for individuals from all the three target groups we spoke to.

Many of the survey respondents frequently mentioned the need for more personalised and targeted information, as the advice given was often viewed as too generic and did not cater to individual needs.

Many expressed a desire for more detailed information on diet and how different food groups affected blood sugar levels. This was backed up by people in the focus groups, highlighting that diet was a crucial aspect of the education people needed. It was also important that information needed to be respectful to different cultures and traditions too.

Some respondents felt overwhelmed by the amount of information provided in a short time and suggested spreading training over shorter multiple sessions or offering follow-up sessions at the end of a course.

A few respondents highlighted the need for pre-assessments to understand individual knowledge levels and interests, and to help to tailor the education packages. This was one of the highest priorities from those who participated in the targeted focus group discussions.

Reponses to the question around what type of information would have been helpful to you when you were diagnosed included aspects of psychological support around lifestyle change, how diabetes interacts with other conditions and weight management.

> *"All the information is great, but more focus on the why, the psychology, the underlying reasons why we find it so hard to stick to and often sabotage our good work is crucial. Change the language about good and bad food."*
>
> A person with diabetes

Several people identified the importance of including this education offer into other training packages, for those who are managing other health conditions.

Many suggested it would be helpful to have information on weight management and exercise techniques, to better understand how carrying excess weight can contribute to other health issues.

It was noted that course content should consider incorporating cultural practices and the preparation of certain foods and foods that are deemed a community's staple foods.

It was also felt that future participants would benefit from gaining a better understanding about food labelling, so that healthy meals could be prepared.

Several respondents noted the importance of emotional support and understanding the psychological impact of living with diabetes, which could be covered in course materials, with support groups being suggested as a good idea to share.

Session timing

The timing of sessions was an important factor as to why people may not attend the education session.

There wasn't a favoured day of the week, however it was clear that weekends were not popular.

Most people mentioned the importance of convenient session times, with many preferring these to take place outside of regular working hours.

Many respondents cited scheduling conflicts as a primary reason for not attending, with several mentioning, through the survey, that sessions were held during the day, conflicting with work commitments, but overall, there was little consistency on this.

Individuals from communities who attended the focus groups preferred that sessions took place during the working week and within their community setting with established groups who regularly meet. This was very important to the people who shared this.

For example, those with learning disabilities said it was important that education sessions should be held during the day, as this is when many received support hours and would require assistance to attend. It was deemed important that staff who supported individuals would also benefit from attending and learning more.

But, for many of those from African, Caribbean, and South Asian communities, it was important to consider times outside of the working day, as many people worked shift patterns themselves or those who may need to accompany them did so.

There was also a varied response to how long people thought the sessions should run for. 30% (3 in 10) said once a week for 2-4 weeks, 20% (1 in 5) said once a week for 7+ weeks and other respondents said somewhere in between.

A few mentioned personal commitments as well as forgetfulness as reasons for non-attendance by those invited. The challenge to cancel or amend sessions was mentioned as problematic too.

Follow-ups training and regular updates were also mentioned as ways to enhance and reinforce learning in case people started to slip back into bad habits and practices. 75% (3 in every 4 people) would attend a refresher course if it was offered.

To conclude, most people felt it was important to offer a range of times and days for delivering these important education sessions, and refresher sessions would be welcomed.

Location

There was a clear preference for local sessions, for a variety of reasons, including work commitments, home commitments, and travel challenges.

A quarter of people (1 in 4) responding to the survey felt the sessions should be in their GP practice, just under another quarter (1 in 4) should be anywhere in the neighbourhood and this was closely followed by the choice of in a local community venue like a church hall, community centre or library.

Within the focus groups the discussion was unanimous, wanting sessions to be delivered at support groups and meeting hubs, at the heart of a community. Several reasons were cited, including being with their peers from their own community which meant they were more relaxed to discuss personal issues because they had a high level of trust and confidence that information would not be ridiculed or shared.

The survey showed that a small number of respondents (15%) would prefer not to attend a venue in person but would rather access the education digitally or online. This was attributed to being more convenient and easier to do around a busy life schedule.

> *"I need a menu - what's on offer and when. I need things to be convenient and at a time I can attend, because I work."*
>
> A person with diabetes

Who should deliver the education offer

Respondents expressed a preference for having a variety of experts in the diabetes education sessions.

- 30% suggested healthcare professionals such as nurses and dietitians or nutritionists
- There was notable interest in including individuals living with diabetes as experts, indicating a value placed on lived experience
- Some respondents highlighted the importance of having experts with specific knowledge in areas like hormones and diabetes management.

The Black African/Caribbean focus groups felt strongly that the expert should be someone who understands the cultural background/heritage and knew the importance of food, especially relating to traditional recipes.

> *"The staff that support me need to know all about me, about how to look after my health"*
>
> Person with Learning Disabilities

Need for bespoke and varied offers

Respondents generally do not find it difficult to access diabetes education sessions, with many explicitly stating no barriers. However, some respondents have mentioned specific challenges in relation to finding it more difficult to access education sessions. These include:

- Cultural contexts
- Being a single parent or a carer
- Other complex physical and learning disabilities
- Social anxiety
- Neurodiverse diagnosis
- Language barriers

There was a strong feeling that bespoke courses should be designed and offered to ensure they were inclusive, which was felt would increase participation.

Culture and community

One of the main themes which came from the focus group discussions talked about the need to consider how some communities are very close-knit and prefer to frequently congregate together, whether that be to socialise or learn.

It was therefore no surprise that almost all from the 3 groups at increased risk of developing type 2 diabetes favoured receiving information and education within their own communities.

Many participants said they would feel much safer and more likely to speak openly if they received education in familiar surroundings, such as a local community centre with people of a similar age and from their own community.

> *"Trusted community groups were the best places to deliver education sessions"*
>
> Black Caribbean female

> *"We would welcome you through our door, but it is more difficult for us to come through the door of NHS"*
>
> Member of Afro fit

Accessible and appropriate information

The issue regarding accessible information was something which was highlighted in every focus group. The main concern was that information was not always in an appropriate communication style for the audience. This included sessions not being available with interpreters for non-English speakers, information in a different language and the content not being inclusive for a specific community. It was also said that often easy read would not be available for those with learning disabilities, the pace of the course being too quick, confusing, and using lots of jargon.

There was a recurring theme of wanting more accessible resources and community support networks to better assist those affected. Some respondents pointed out the challenges of navigating healthcare systems and the need for clearer communication from healthcare providers.

> *"For me, too much information delivered really quickly is a sensory overload. Information also often contains loads of jargon which I don't understand"*
>
> **Person with neurodiversity needs**

Taboos and Stigma

For many who shared their thoughts in a focus group, especially older people from African-Caribbean and South Asian communities, they remained silent about their health, with some viewing health conditions as a source of shame or even a "curse", often believing it's linked to wrongdoing. This prevents open conversations, even with family members. This often resulted in a delay in receiving treatment until they become quite severe.

Therefore, many said that they would not attend sessions, with those that they didn’t know.

Gender bespoke sessions

The majority of those who we spoke to from African-Caribbean and South Asian communities said they would feel much more comfortable and are more likely to participate in education sessions if these were delivered in women and men only groups.

> *“Separate sessions for men and women, women feel they would attend more than men, but they would definitely need a separate group”*
>
> **South Asian woman**

Food preparation

For some communities, food was said to be an important and a central part of the cultural identity. It's not just about what people eat, but how, where and when they do. This included staple foods which were often traditionally made with high levels of fats or sugar, therefore a focus on adapting recipes which substituted some unhealthy foods with healthier ones would be beneficial. It was also mentioned that recipe ideas should reflect the community and for some, regional variations too.

> *“Food is important, when we eat and how we eat is a huge part of our way of living”*
>
> South Asian woman

Barriers to accessing health services

It was mentioned from some of the diverse communities we talked to, that many people work unsociable hours, which limits access to health services. Therefore, a digital offer might increase uptake.

This was completely different for many older adults who may not have access, skills, or knowledge of using online services and may feel uncomfortable asking their children for help to access online sessions.

As cited earlier, many mentioned that language can be a barrier, especially some South Asian communities.

Some respondents expressed a desire for resources in other accessible formats, such as British Sign Language and screen reader-friendly materials, indicating a potential current service gap.

Accessibility issues were also noted as potential barriers, such as the lack of a transport for those with mobility challenges as well as more consideration needed to ensure venues were suitable for those with additional needs.

Wider offer to family and carers

It was widely viewed that it would be beneficial if the offer of training could be extended to include other members from a whole household, including children of an elderly parent as well as in some cases, grandchildren. This was deemed essential too in relation to the preparation of food, with women typically preparing all meals in some cultures. By educating all family members, it was thought this could have a ripple effect so different generations could learn useful information.

The focus groups held with people who have learning disabilities clearly stated that there should be consideration for family members, friends, or carers to be able to attend sessions to offer support. These groups highlighted that they often required assistance with shopping and cooking or total reliance on having food prepared for them, so that it was important for others to also receive education too.

> *“I can’t do what the training says without the support of my family or staff”*

Professional View

Professional feedback was limited, but for those who did take part, there was a suggestion that the process was more complex than necessary and advocated for integration with GP practices for more personalised education.

Some respondents highlighted the use of both online and face-to-face education, with a focus on allowing this to be a patient-led decision.

Many professionals frequently highlighted issues with the current SDE programme, particularly regarding these not being accessible, with little to no engagement with providers. Many noted that the programme was poorly attended, with barriers identified as inconvenient scheduled sessions for working individuals.

There was a call for more face-to-face sessions, so patients could be invited soon after diagnosis and didn't have to wait long periods to start the programme. This often led to patient disengagement.

It was mentioned that professionals had received feedback that the programme was too scripted, lacked consistency of content and didn't always cover the things patients required.

It was felt that additional funding was required, and staffing issues were a contributory factor to why the service wasn't being delivered effectively.

Most of the feedback suggested that there needs to be improvements to the offer including that it should be automatically offered after a type 2 diabetes diagnosis.

It was also believed that education packages should be available in multiple languages.

There was a desire for better communication about patient attendance from providers, so that practitioners could record whether someone had participated and if not, additional support could be offered.

There was a call for more clinical messaging and localised publicity to raise awareness of the programmes.

Section 4: Health inequalities

Inequalities

As set out above, people reported inequalities in relation to access and experience of services for specific groups. These barriers prevented some people from accessing services in the same way as others or when using services, they felt that their needs were not considered or that they were not treated fairly.

Neurodiversity and Disability

It was strongly felt that the current structured diabetes education offer was not suitable for some people with disabilities. Some people felt that venues were not always accessible for wheelchair users and that the material wasn't in alternative formats, specifically in easy read for those people with learning disabilities.

It was suggested that bespoke co-designed educational packages should be developed, and sessions should be ideally delivered in small groups, in partnership with organisations who support people with disabilities. This would ensure the educational offers were more inclusive which could have a positive impact on attendance and participation.

Race

It was strongly felt that the current SDE offer was not suitable for different communities, especially those where English isn't their first language. Many felt that if materials were widely available in alternative languages and delivered by facilitators in native tongue, this would improve those undertaking the sessions to understand the information.

It was suggested that bespoke co-designed educational packages should be developed, and these sessions should be ideally delivered in small groups, with partnership organisations who support the community of interest. This would ensure the educational offers were inclusive and could increase attendance rates.

Religion

It was strongly felt that the current SDE offer did not consider all the religious and cultural needs of different communities.

Many felt that that sessions should be delivered by gender, as some religions do not allow different sexes to mix outside of the home.

It was suggested that bespoke co-designed educational packages would be beneficial delivered in partnership with organisations who support the community of interest. This would ensure the educational offers were more inclusive which could have a positive impact on attendance and participation.

Image 3: Afro Fit, Gorton, Manchester

Section 5: Key points to consider and next steps

Key points for commissioners to consider

There are a number of key issues that have emerged from the public engagement, for the commissioners to consider.

1. Structured diabetes education is an essential service to assist those with type 2 diabetes to understand and manage their condition effectively, but firstly the referral process needs to be improved to ensure that all those who are eligible receive an invitation to attend.
2. Although it's clear that the current delivery model works for some, and a combination of face-to-face sessions would work for different people, a one-sized fits all approach is ineffective and serious consideration needs to be given towards course content, which should reflect the gaps in skills and knowledge for different people.
3. There is clearly an appetite from different communities and groups to be involved in co-designing education packages, which better reflect the needs of different communities, especially those identified to have an increased risk of developing type 2 diabetes.
4. Any face-face courses should be delivered by diabetes specialists, accompanied by supporting literature in a variety of different languages and formats.
5. A more culturally and demographically competent offer could help increase uptake in SDE, which would help those living with type 2 diabetes to manage their condition more effectively. This could also reduce reliance on primary and secondary care and reduce the need for treatment for health complications linked to the condition.

Next steps

This report will be shared with those responsible for commissioning and delivering services.

Commissioners will use the information to check their proposals for change and ensure they reflect what people have told us.

We will update the equality impact assessment using the feedback and the things we have learnt.

We will continue to engage people when developing and evaluating services including any new models that are proposed.

We may explore setting up a lived experience group to support us to co-design future education packages.

The report will be published on our website and shared with those directly involved through focus groups etc, along with regular updates on what has changed as a result of the engagement.

If you would like to be kept up-to-date, or get involved in the next steps, please contact us:gmhscp.engagement@nhs.net or 07786 673762.

Section 6: Glossary and accessibility

Glossary

Blood glucose levels

How much glucose (also known as sugar) is present in your blood.

Blood sugar

How much sugar (also known as blood glucose) is present in your blood.

Clinicians

Doctors, nurses, consultants, or any other health care worker who treats patients directly.

Glucose

Glucose is the main sugar found in the blood and so when people talk about diabetes, they often use the word glucose and sugar interchangeably.

Health inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

HbA1c

HbA1c is the average levels of glucose (sugar) found in blood for the last two to three months.

Hormones

Hormones are chemical messengers that coordinate different functions in your body. Insulin is one hormone and is the most relevant one to diabetes.

Hyperglycaemia

Hyperglycaemia occurs when the level of glucose in the blood is too high.

Hypoglycaemia

Sometimes known as a “hypo,” hypoglycaemia occurs when the level of glucose in the blood is too low.

Insulin

Insulin is a natural hormone that turns food into energy and manages your blood glucose level. People with diabetes sometimes need extra insulin to help them manage their blood glucose.

NHS Greater Manchester

NHS Greater Manchester is responsible for commissioning most health services across Greater Manchester, including hospital, community and mental health services, GP practices, dentists, optometrists, and pharmacists. This means that it is responsible for managing the contracts, making sure they deliver good quality care, and paying for the NHS services that they deliver.

NICE

The National Institute for Health and Clinical Excellence (NICE) provides national guidance and advice to improve health and social care.

Structured Diabetes Education

Structured Diabetes Education is a short course of usually face-to-face education sessions which are designed to give people newly diagnosed with type 2 diabetes the information they need to manage their condition. Sometimes it is offered online instead of face-to-face.

Type 2 diabetes

Type 2 diabetes is a common condition that causes the level of glucose in the blood to become too high.

Accessibility and translations

If you would like this information in another format, or translated into a different language, please email gmhscp.engagement@nhs.net

如果您希望以其他格式获得此信息，或将其翻译成其他语言，请发送电子邮 件至 gmhscp.engagement@nhs.net

Jeżeli chciał(a)byś otrzymać te informacje w innym formacie lub w innej wersji językowej, prześlij wiadomość na
adres gmhscp.engagement@nhs.net

Pour obtenir ces informations dans un autre format ou dans une autre langue, veuillez adresser un e-mail à gmhscp.engagement@nhs.net

إذا كنت ترغب في هذه المعلومات بتنسيق آخر، أو مترجمة إلى لغة أخرى، يرجى
إلى الإلكتروني بالبريد رسالة gmhscp.engagement@nhs.net إرسال

ਜੇਕਰ ਤੁਸੀਂ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਨਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ gmhscp.engagement@nhs.net ‘ਤੇ ਈਮੇਲ ਕਰੋ

اگر کسی اور فارمیٹ، میں یا کسی اور زبان میں ترجمہ شدہ آپ کو یہ معلومات چاہیے، تو براہ
gmhscp.engagement@nhs.net کرم پر ای میل

Haddii aad rabto in aad macluumaadkan ku hesho qaab kale, ama lagu soo turjumo luqad kale, fadlan farriin iimayl u
dir gmhscp.engagement@nhs.net

Dacă doriţi aceste informaţii în alt format sau traduse într-o altă limbă, vă rugăm să trimiteţi un e-mail la gmhscp.engagement@nhs.net

আপনি যদি এই তথ্যটি অন্য ফর্ম্যাটে বা অন্য ভাষায় অনুবাদ করতে চান, তাহলে অনুগ্রহ করে এখানে ইমেল
করুন gmhscp.engagement@nhs.net

Si desea recibir esta información en otro formato o que se traduzca a otro idioma, envíe un mensaje a la
dirección gmhscp.engagement@nhs.net

Section 7: Appendices

Appendix 1: Survey equality monitoring data

Although the survey asked respondents to complete equality monitoring questions, this was optional.

To this end, the demographic information contained within each dataset is not representative of all those who completed the survey.

Chart 1: What area of Greater Manchester (GM) people live in

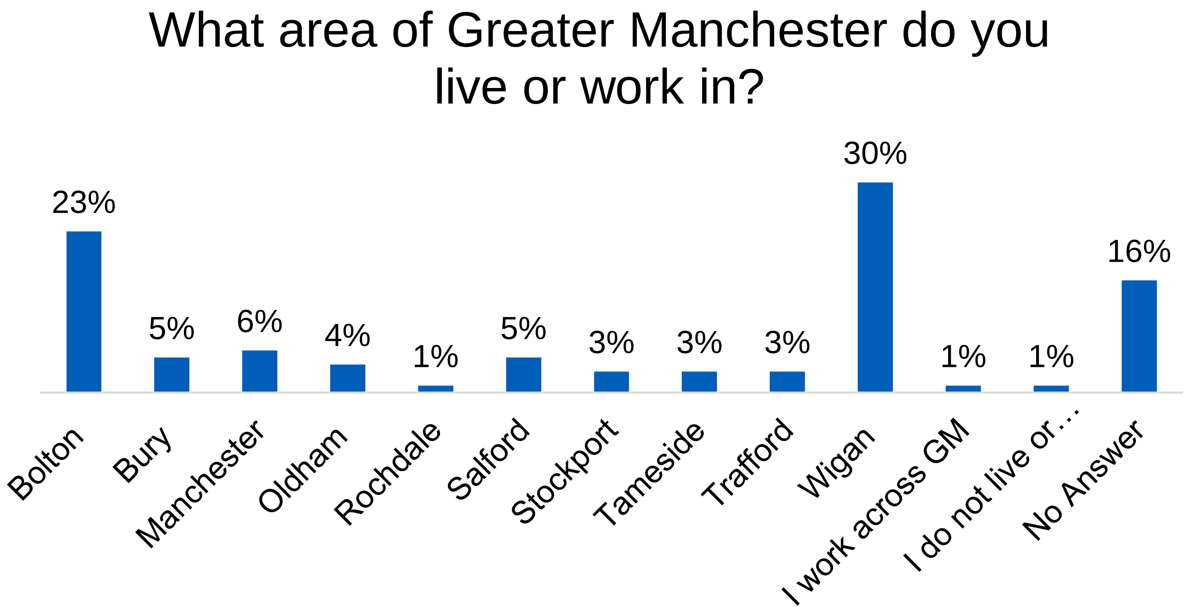


Chart 2: Age

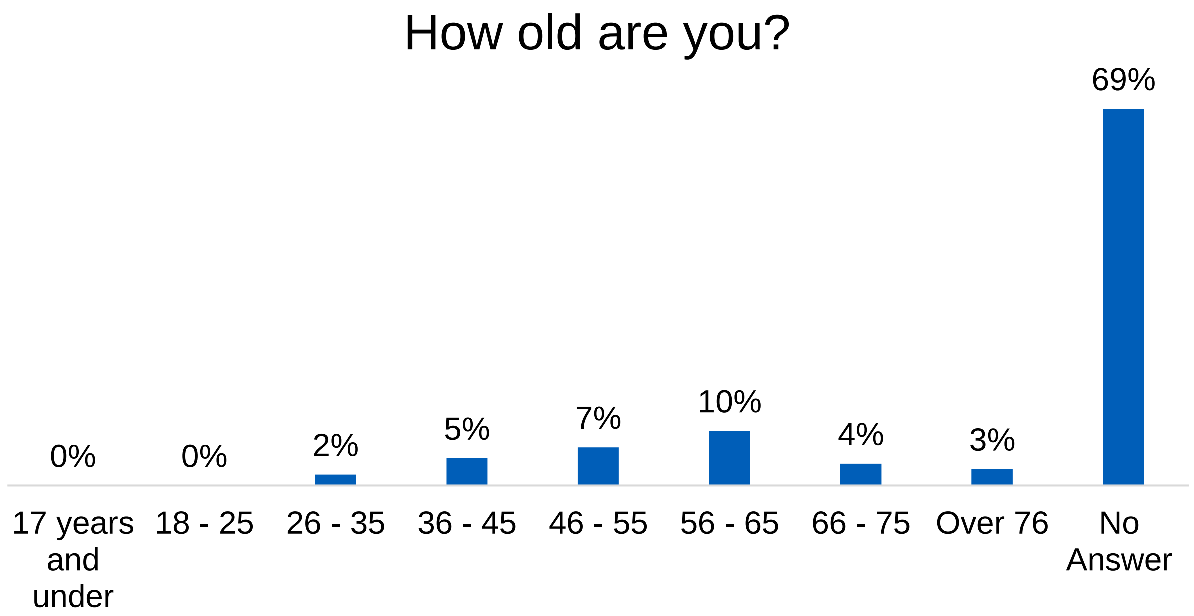


Chart 3: Ethnicity

What is your ethnicity?

Respondents predominantly identify as White British, with multiple individuals explicitly stating this ethnicity. There are also responses indicating White European, British White, and simply White as their ethnicity. One respondent specifies Romanian, indicating a presence of other European ethnicities within the group.

Chart 4: Gender

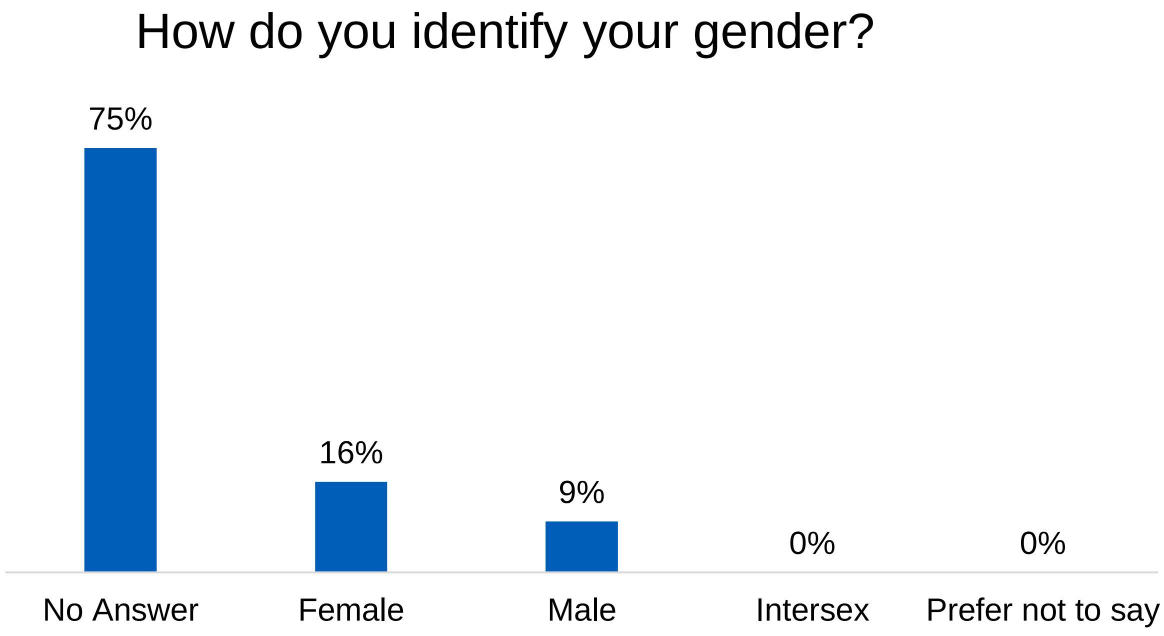


Chart 5: Gender the same as described at birth

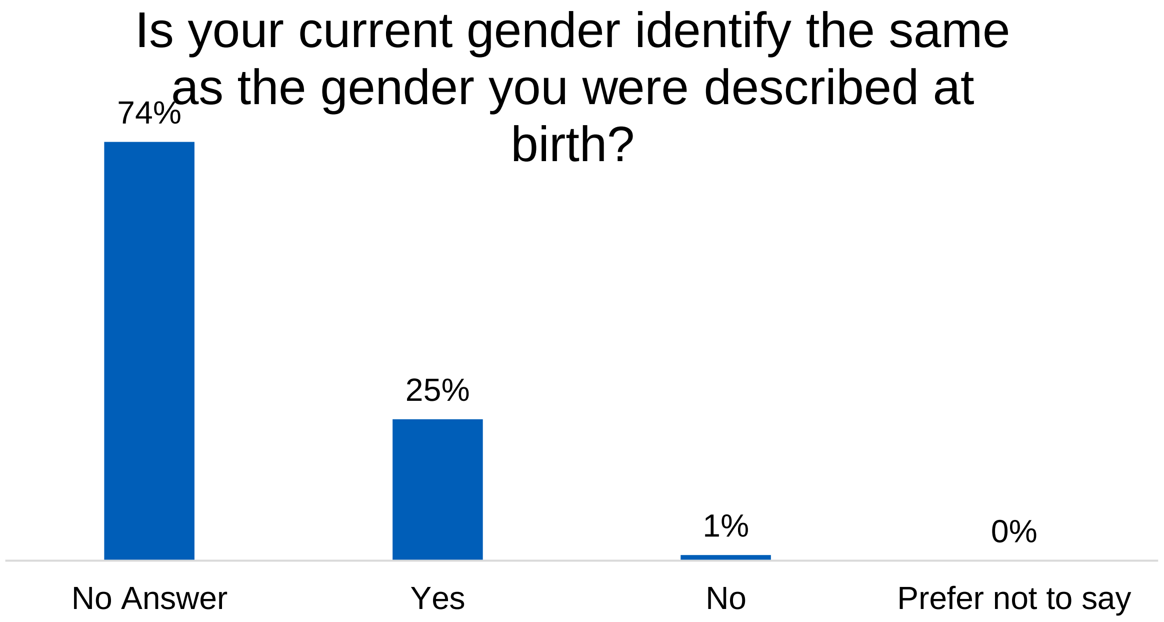


Chart 6: Relationship status

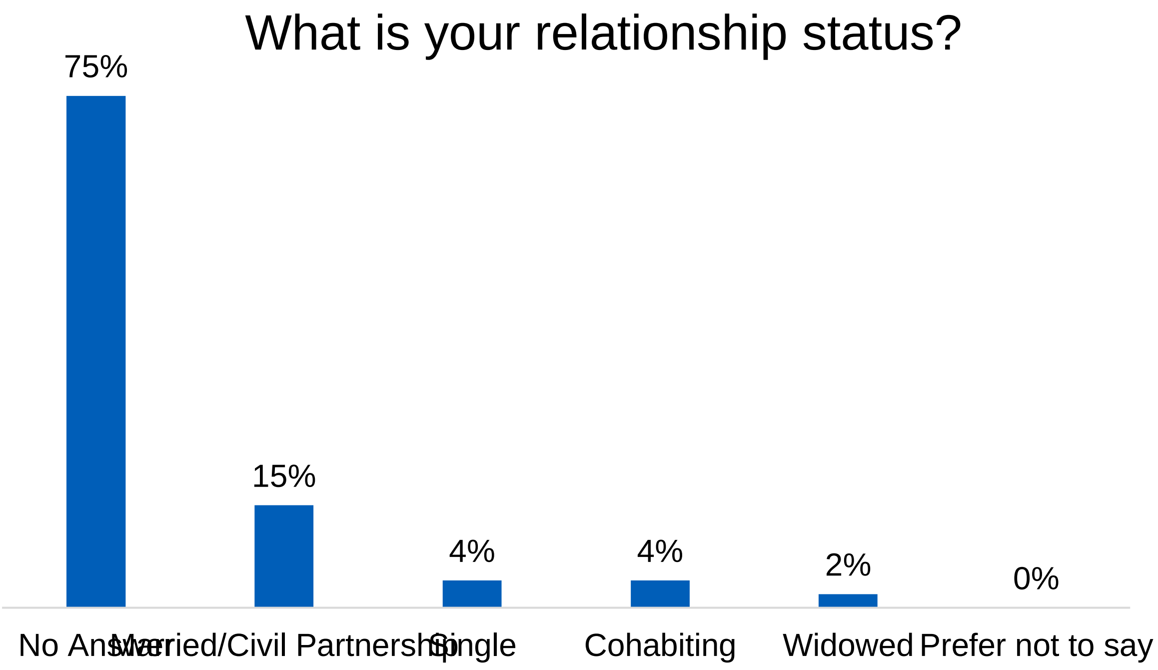
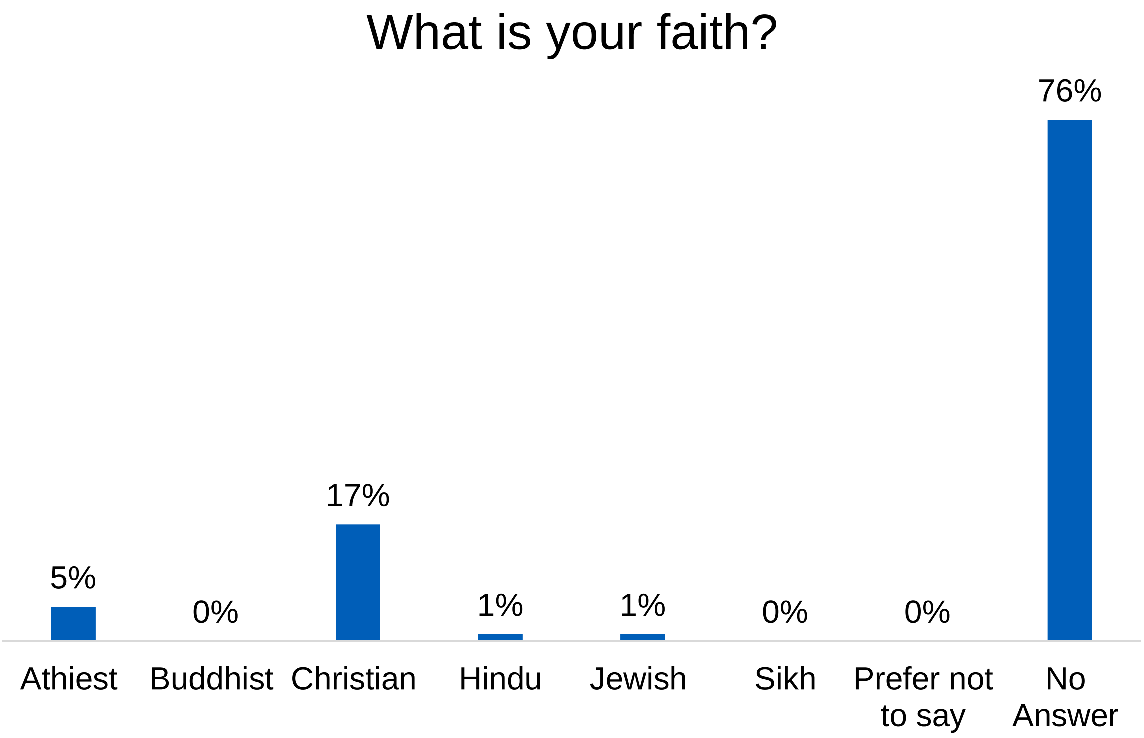


Chart 7: Faith



Three people said other for faith which included Salvation Army, Agnostic and Pagan.

Chart 8: Sexual orientation

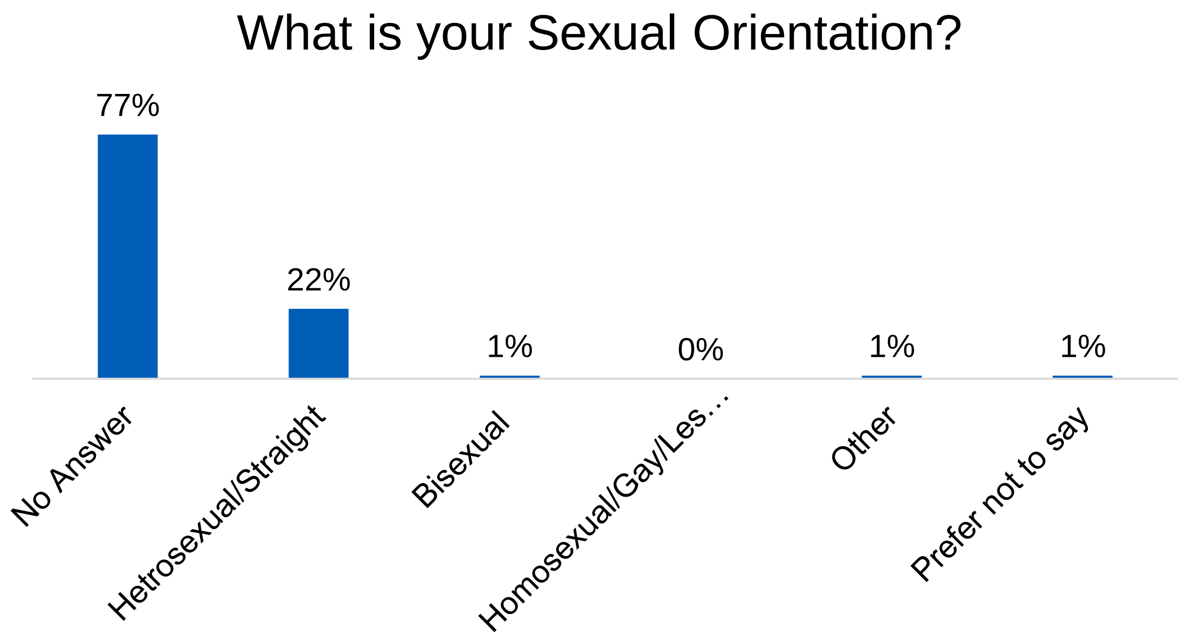
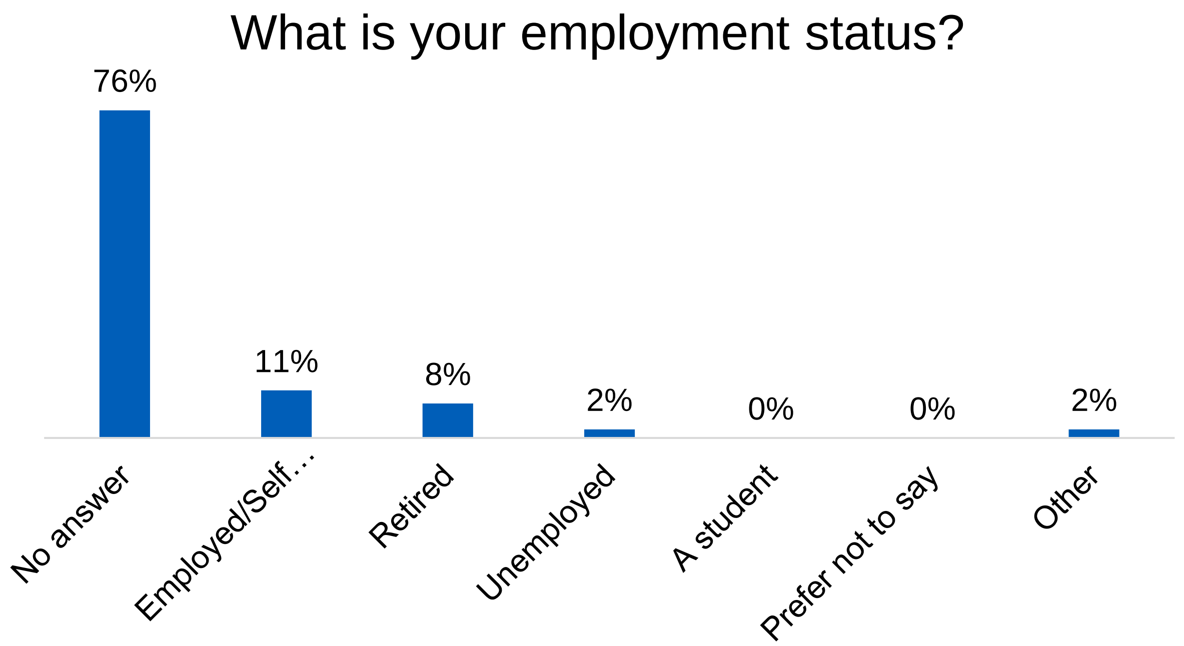
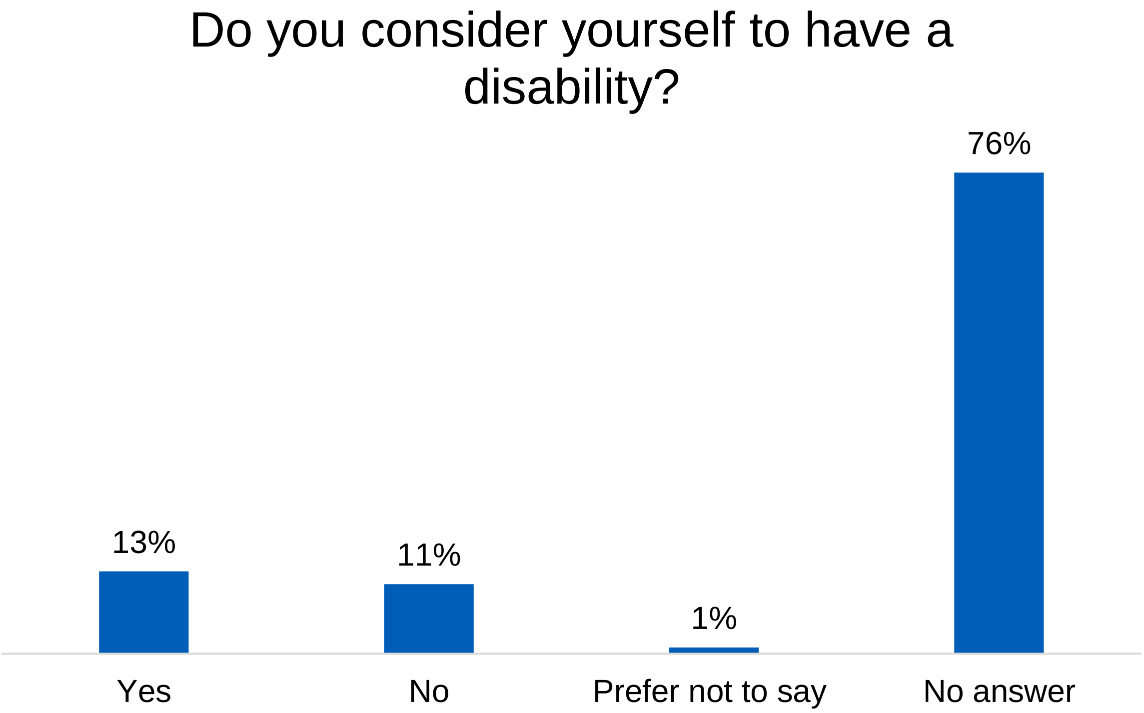


Chart 9: Employment status



Other responses included carer for family member and volunteer.

Chart 10: Disability



Of those who said “Yes,” 19 people shared further information about their condition, this included:

- Long Covid
- Lymphoma, diabetes related complications feet ulcers and eyesight problems, incontinence, low blood pressure
- Macular degeneration
- Mobility
- Mobility issues
- Mobility problems. I use an electric wheelchair.
- Scoliosis. Arthritis. Meniere’s. High BP

Chart 11: Armed forces (currently serving and veterans)

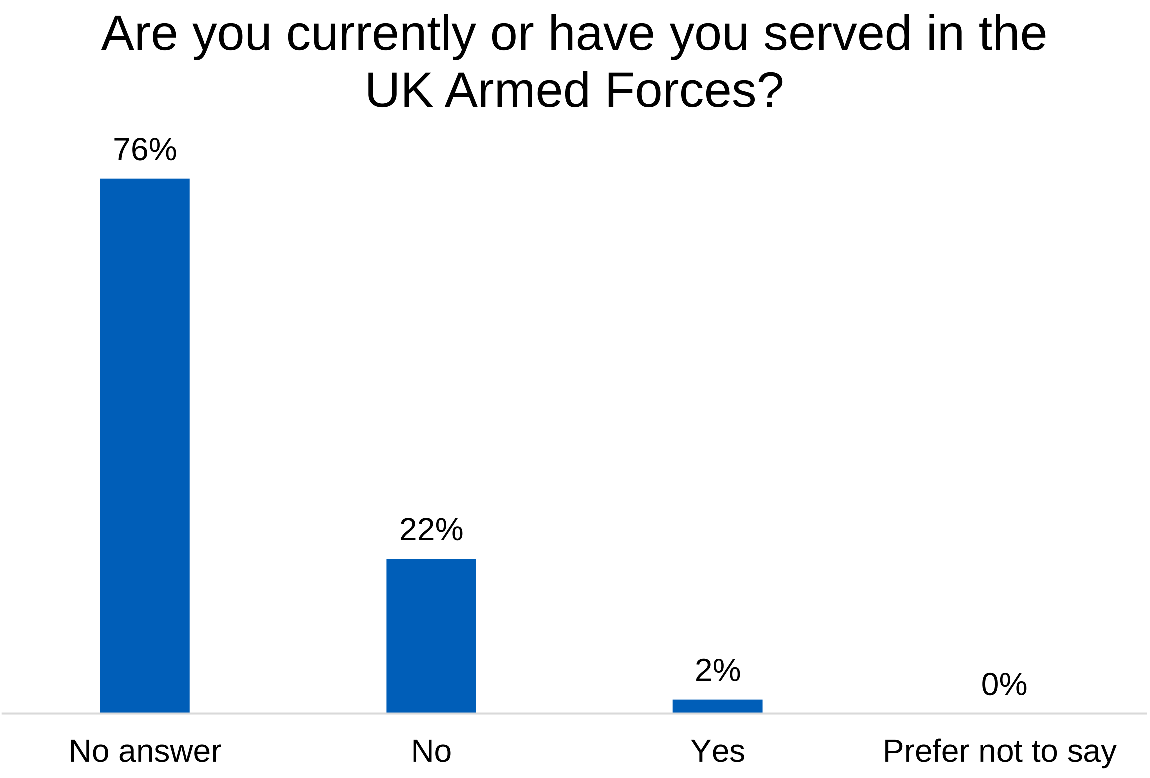


Chart 12: Carers

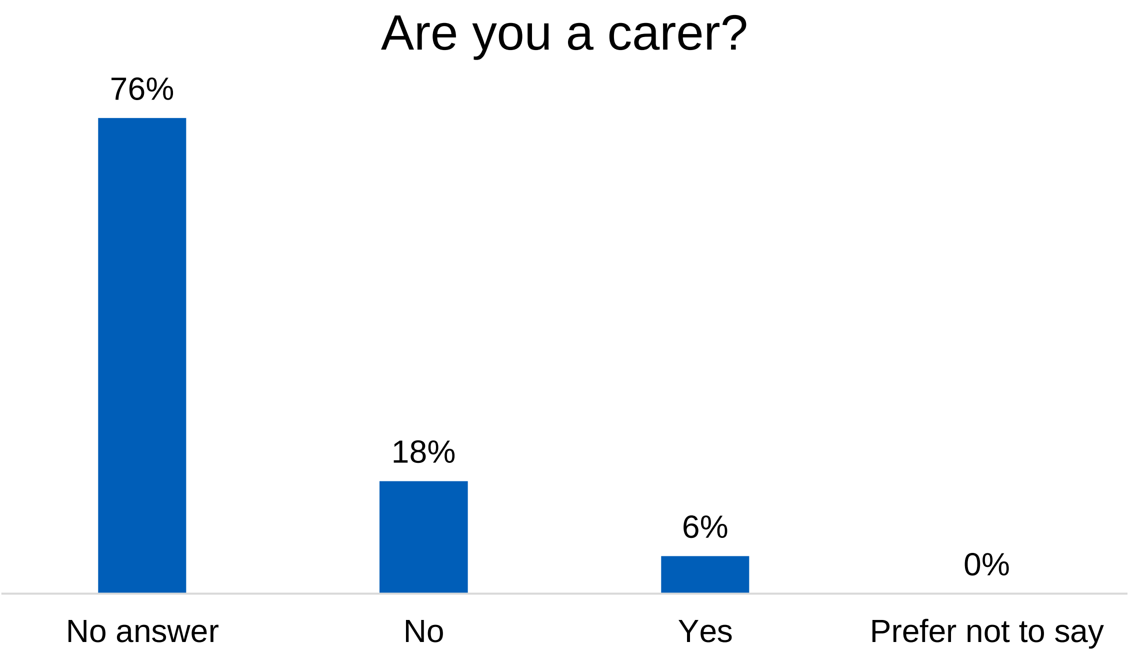


Chart 13: Pregnancy