

Executive Summary

1.0 Introduction

NHS Newcastle North and East Clinical Commissioning Group (CCG) and NHS Newcastle West CCG are carrying out a review of type 2 diabetes education being provided to newly diagnosed patients.

The overall aim of this project was to test and explore type 2 diabetes patients' views on a draft service specification for structured diabetes education, to inform the final specification and future service provision for diabetes.

The key objectives of the project were to:

- Gauge awareness and uptake of current diabetes education courses
- Explore experiences of current education courses
- Identify any barriers to patients attending the current education courses
- Gauge levels of self-management amongst patients and any required support
- Discuss proposed education courses with patients and identify their preference and expectations of that course
- Explore patients preferences around location, timing and composition of courses
- Identify any barriers to the uptake of courses and suggestions for encouraging uptake
- Identify any other ways to receive education around diabetes

The project sought to engage with type 2 diabetes patients who had:

- Been newly diagnosed within the last 12 months
- Established diabetes with a diagnosis between one and five years ago

Via face-to-face interviews or online questionnaires and focus groups 94 people gave their views:

- Involve North East spoke to 84 people (see Appendix 4 for details)
- HAREF spoke to six people from black and minority ethnic communities (see Appendix 5 for details)
- Deaflink spoke to four people who were D/deaf (Deaf with a capital 'D' refers to those who identify with the Deaf community and culture and deaf with a lower case 'd', to those who are deaf and do not identify with the Deaf community) and others with sensory issues such as deafblind, Hard of Hearing and visual impairments

HAREF had a positive response to their recruitment drive with over sixty people interested in taking part. However, as the criterion for the work was those who had been more recently diagnosed, only six were eligible and took part in the engagement. The experience of one person who did not eventually take part in the research is worth noting however as it illustrates communication issues with people who have English as a second language around diagnosis of a condition.

This person from the Czech Republic was identified as having diabetes by their GP practice and invited by letter to take part in an interview. HAREF arranged language support for a telephone interview but at the beginning of the interview the person

said that they did not think they had diabetes. This confusion illustrates the complexity of providing primary care support in the area of diagnosis of long term conditions, in which a lot of explanation and discussion is needed. Medical groups have highlighted the practical issue of managing appointments to meet need, in terms of the time required in interpreter supported consultations to ensure people have understood the information from health professionals.

Deaflink expected to engage with a low number of people due to the fact that D/deaf people are more likely to have undiagnosed diabetes ('Sick of It – Report into the health of deaf people', Signhealth, 2014). Sixteen people actually came forward to take part in the research but only four had been diagnosed within the last five years.

2.0 Current and proposed services

Currently, newly diagnosed patients living in the city are able to access two main services:

1. Diabetes Education and Self-Management for Ongoing and Newly Diagnosed course (DESMOND)

Patients are invited to attend DESMOND and this consists of two three-hour sessions, one week apart which take place at the Diabetes Centre, located at the Campus for Ageing and Vitality on Westgate Road. Up to 10 patients can attend (and can bring someone with them). The sessions are led by health professionals who are trained to ensure that patients are provided with up-to-date, evidence-based information. The course helps to educate patients about the type of diabetes they have, and provides practical advice on self-management of their condition. The course is not available for patients who require an interpreter or who are housebound.

2. Living well, taking control (LWTC)

This course is a pilot and has been operating for the last nine months, provided by HealthWORKS Newcastle. Again, newly diagnosed patients are referred to the course by their GP. It aims to help patients improve their lives and manage the condition and reduce longer term complications linked to diabetes. It consists of a set of six two hour group sessions which cover eating well, feeling good, stress and relaxation and reaching and maintaining the right weight. In addition, one-to-one support from a qualified health buddy is provided where attendees discuss their health and how to improve it. It is held at three community venues across the city at a variety of times, including morning afternoon, evening and weekends and participants may also bring along a carer, family member or friend.

The CCGs have drafted options for a new service specification for diabetes education which the engagement will help inform. The following three options have been developed although it should be noted that the final diabetes education service may include elements of all of them dependent on the outcome of the engagement:

- Education Option 1
 - This course would continue as described in DESMOND above

- Education Option 2
 - The course would take place in a community setting (e.g. a community centre)
 - Patients would attend more sessions than DESMOND which would be shorter in length, for example, six sessions of 2 to 2.5 hours. Sessions would be available during the day, on evenings or on weekends
 - It would be led by a healthcare professional trained to deliver education and there could also be trained community workers to support people further
 - This would be available in groups of 10-12 (plus family/carers) for English speaking groups and black and minority ethnic groups where they speak a language which is spoken by more than 3% of Newcastle's population
 - For members of the black and minority ethnic community where their language is spoken by less than 3% of the population, there is an option for group education if enough people are available or they would have individual 1:1 sessions
 - For those who are housebound, who are care home residents or who have learning disabilities, non-group options would be available with a method more appropriate to their needs
- Education Option 3
 - This would be a computer-based course for those who have little time or would prefer not to attend classes
 - It would offer a shorter, briefer course with less information
 - It could be available in other languages if developed

3.0 Findings

3.1 Diagnosis and initial information

Of the 94 patients who took part in the research, 44.7% (42) had been diagnosed within the last year and 55.3% (52) had had their diagnosis for between one and five years. The majority of people had no symptoms of the condition and were unaware that they had the condition as it was either discovered after a routine blood test, they had presented at their GP with an unrelated illness or it was picked up during treatment for another condition they had.

“I just had my regular yearly check-up and it showed up in my blood tests. It's just over 6.0 but to be honest I've never felt better!”

Four-fifths of people (76, 80.9%) received some information at their initial diagnosis about next steps, diet and weight loss, either in the form of written or verbal information. Thirteen people (13.8%) did not find the information useful and this was mainly due to the inaccessibility of it. Three HAREF participants found it difficult to access because of their level of English skill. One person who was blind was given a leaflet and another who was D/deaf found the language difficult to understand. The majority of those who did not receive information would have liked some (13 of 18, 72.2%) and information on diet, calories and recipes (taking into account the sorts of food that people cook across communities) was most frequently requested.

“No, I was given pamphlets and I am blind”.

“I would have liked diet stuff to begin with, example meals I could cook straight away”.

3.2 Experience of educational courses

Seventy-five (79.8%) had been offered the opportunity to attend either the DESMOND or LWTC educational course and two of those people had been offered both. Of this group 61 (81.3%) attended a course although two people chose not to attend the second DESMOND session.

3.2.1 DESMOND

3.2.1.1 Attendees

Fifty-six people (82.4% of those offered) attended DESMOND. Referred by their GP or Practice Nurse they attended the Diabetes Centre, Brunton Park Health Centre or Molineux Street NHS Centre. Most people had expectations of the course and these were around being given general information about the condition or information about diet and foods to eat or cut out.

“Help in knowing what would affect diabetes and to be explained exactly what diabetes is”.

Nearly two-thirds of people (24, 61.5%) felt that their expectations had been met and their experience was a positive one. They enjoyed meeting other people, sharing experiences, the course leaders and the format.

“They gave very good information, presented in different ways and reinforced the message over the two sessions. The shared experience you get from the course was brilliant too. I think the social side is very important to go through the journey”.

Those 13 (34.2%) who felt expectations had not been met cited the skills and knowledge of course leaders, the content of the course being too much or too little information or not personalised, the intimidating large group size or the length of the session. One D/deaf participant was unhappy as they learnt that despite a support group being in operation in the city, there was no funding for D/deaf people to access it. Another three people commented that the sessions were too long, there were no refreshments and for one D/deaf person the fact that it had taken eight months to get onto the course due to interpreter bookings/fee issues. Also, for two HAREF participants there was a language barrier; they felt that it was very difficult to understand the information because the session was long and the language was complicated.

“There were two nurses delivering the course, one was very knowledgeable and the other just kept apologising for not knowing much and being new which is ridiculous to admit. I dread to think how others in the room with no medical background would have felt. To be honest, I left after that first bit as I was appalled”.

“I learnt there is a group that meet but no funding for the Deaf to access it. They have speakers which supplies information. I got more understanding of

diabetes but by this time I had lost interest and couldn't care less what happens after realising the discrimination and lack of respect“.

Three-quarters of people (42, 75.0%) had been given ongoing support once the course had ended in the form of a manual/booklet to work through and urine blood glucose test kits. Three people said they were referred to HealthWORKS for lifestyle support and exercise. Eight people (19.0%) did not find the information useful due to the lack of detail within it. Seventeen participants (30.4%) requested other support, mainly around having follow-up session to check the progress of attendees within a year of the course. Six HAREF participants respondents requested follow-up sessions within their community-based groups to top-up messages about diet changes and where to go to exercise.

“Well, I think it would be better to have a follow-up after the course to check you're doing okay and just so you don't feel you're forgotten”.

3.2.1.1 Non-attendees

Those 12 people (17.6%) who were offered the course but did not attend described their reasons. Five were simply waiting for their start date, four people felt they knew enough about the condition and three people had been unwell. All but three said that they would consider attending in the future; two felt that they knew enough and one said that they were happy to just go to the dietician.

“My brother and sister also both have type 2 diabetes and they told me everything”.

3.2.2 LWTC

Seven people (100.0% of those offered) attended the LWTC course. Referred by either their GP, Practice Nurse or a Health Trainer or finding out about it themselves, they attended the HealthWORKS building, Lemington Centre or Fenham Sure Start Centre. All felt their course expectations had been met and were very positive about it citing the interesting information and practical sessions in particular. They all received ongoing support in the form of a buddy who keeps in touch with them at regular intervals and received a booklet to take home and complete.

“It's a good approach with a lot of visual information...The group has been really useful for stress control and for recognising a range of symptoms that other people were describing, because I had been thinking I was going mad. It was so helpful to hear people talking about anxiety and I could think to myself 'It's not just me. It does happen to other people'. It was interesting listening to people from other cultures and hearing about different foods. There is a lot of home cooking in south Asian communities and so people don't always know how to work out what's in the food - there might not be any label. The healthy eating cooking sessions are very good because I've picked up things like using fromage frais and low fat yoghurt”.

3.2.3 Non-attendees

Nineteen people (20.2%) had not been offered the opportunity to attend an educational course and of these 11 (57.9%) had been diagnosed less than 12 months ago. Sixteen (84.2%) said they would consider attending in the future, one said they would not attend and two D/deaf participants did not answer.

3.3 Managing the condition

All but nine participants (9.6%) had made some sort of lifestyle change since being diagnosed, with the majority improving their diet and others exercising. Of the nine, five people said nothing would help them manage their condition, two requested more personalised information or exercises sympathetic to their disability or condition, one requested diet information, another recipes. Ten people (23.3%) requested something to help their family to support them with their condition mainly in the form of diet information.

“I realised it’s not what I eat it’s how much when they showed me the plates on the course so I’ve cut down how much I eat”.

“They find it difficult to help because they don’t understand the eating pattern ‘you can have a little’ or ‘I know diabetics who eat this’ ‘well I won’t have any then’ and you feel guilty”.

3.4 Preferences of proposed changes to education courses

Option 1 - Structured DESMOND course

Option 2 - Within a community setting

Option 3 - Computer-based course

Participants were asked to consider which of the three proposed diabetes education course formats would suit them best if they were to consider attending a course in the future. The following options were chosen:

Preferred course	No. of responses*	% of participants
Option 1	34	36.2
Option 2	49	52.1
Option 3	9	9.6
No preference	1	1.1
None	2	2.1
Total	95	

*One participant could not choose between option 1 and option 2

3.4.1 The preferred option - Option 2

Option two was the preferred choice for the largest number of participants. The two main reasons for choosing this option were the preference for attending a course in a community setting so that they did not have to travel too far, were in a familiar setting and did not have the anxiety of going to hospital. They also preferred to have more sessions that were shorter in length, which would give them the opportunity to take the information in and formulate questions for the next session

and be given the information in more manageable chunks. Eleven people (22.4%) liked the chance to meet people, including those from their local community and build up a rapport over a period of time and share ideas. Seven people liked the flexibility of the times and for a further seven having the course available in other languages was very important. All HAREF participants highlighted the value of bilingual workers as language can be a significant barrier to attending.

“Bringing sessions out to places like here [venue of regular social group supported by the local authority] means it would get to people with a diagnosis of diabetes and their family members, as well as friends who might need to know things because there is diabetes within their families, or to be able to avoid developing diabetes.”

“This will give you more time to digest the information and to get to know the group. The course I went on was rushed (DESMOND) - it would be better if it took longer with more time to digest the information and ask questions”.

Participants wanted to learn a variety of things from the course but in particular information about diet – what food they can and cannot eat and in what quantities - and seven people requested the same content as the DESMOND course, seven wanted information on how to manage their condition and seven, including six HAREF participants wanted information on how and where to exercise. One D/deaf participant felt strongly that the course should focus on imparting facts and not the sharing of attendees' experiences as this resulted in the session they attended running over and their interpreters having to leave before all the information had been given out.

“What foods to eat, the seriousness of diabetes and how to stop eating the foods that are bad for you”.

“The same things that were covered on DESMOND but a bit more information on foods you could eat like a ratings system”.

Seventeen people (34.7%) however requested changes to this course, either by including aspects of the other courses or suggesting new things to include:

- Online information to support the course from a trusted source that they could refer back to x4
- Session times to mirror DESMOND x3
- Longer sessions
- 10 sessions, an hour in length
- Hospital setting x2
- Held at Deaflink
- Better management of attendees
- Smaller group size
- Follow-ups x2
- BSL interpreters available x2
- Information in Plain English and visual accompaniments e.g. Illustrating changes in the thickness of blood by showing water on its own and water with different concentrations of sugar in it, going through a straw.
- Include a cookery session

- Give the same information in different formats to reinforce the message

Two-thirds of people expected information to support them once the course was finished mostly in the form of leaflets, access to a helpline or manual.

3.4.2 Option 1

By far the most frequently mentioned reason (23, 69.7% of participants) for choosing Option 1 was the longer sessions over a shorter period which got it over and done with. Also seven people (20.6%) had been on the DESMOND course before and felt it worked well for them. Five people (14.7%) preferred a hospital location. They mostly wanted to learn about diet and the effects of the condition.

“I'd prefer to get it over and done with in longer sessions”.

“For me, it would be better to get the time off work for just a couple of sessions than a whole course”.

“I'd want to learn more about the glycaemic index to find a list of good and bad foods”.

“Portion sizes, list of sugars and carbs in common foods, high risk foods, foods that have a green light, information on sugars in alcohol and alternatives”.

Fifteen people however requested changes to this course, either by including aspects of the other courses or suggesting new things to include:

- Online information to support the course from a trusted source that they could refer back to x3
- More flexible times x3
- Community setting x3
- At home
- Include information about statins and diabetes
- More detailed information
- Clarification about high vs low carbohydrates diets
- Time to ask questions
- Remove the round robin introductions
- Larger room size
- Longer course
- More flexible times
- Different course leaders

Again the vast majority of people (97.1%) expected information to support them once the course was finished mostly in the form of leaflets.

3.4.3 Option 3

Nine people (9.6%) chose the computer-based option. The reasons given for choosing the computer option were that people could do it in their own time, they can do it at home and on their own, it is shorter than the other options and they can

review the information and take time to understand it. They wanted to learn about diet mainly. One person requested a change to the course to include more tailored information. People requested a booklet, online information or access to a helpline and the chance to meet other diabetes patients.

“The computer would be best for me - I can do it in my own time, I don't have to go anywhere, I don't have to sit in a room with lots of strangers, it's just more convenient”.

“When learning in a course via BSL, easy forget after the course and prefer on the computer so can read again and again repeat but want BSL on the computer to understand diabetes information better. I have a computer at home”.

3.5 Preferences of education courses generally

In addition to being asked their views around specific course formats, participants were also asked generally what their preferences were for a course location, leader, group type, time and duration.

Over half of people (53, 56.4%) requested a community location due mainly to convenience and feeling uncomfortable in a hospital setting and for HAREF participants, the reach of the course, as family members and friends and other people with the condition may be able to attend. One fifth of people (20.2%) had no preference of location. Everyone was happy to have sessions run by nurses or healthcare workers who were knowledgeable about the condition but one D/deaf person requested that they also had deaf awareness training and training materials to reflect that.

In terms of group types, 76.6% (72 people) had no preference. However, all six HAREF participants felt that having community-based groups was important so that family members and friends could also attend, four people asked for groups by age and three by similar blood glucose score, two people requested a group with other D/deaf people and one requested a single gender group. In terms of times and days, 28.7% of people (27) had no preference, the main times for others were daytime or mornings and weekdays. For the duration of the course and in contrast to the overall preference for Option 2, more people (41, 43.6%) requested longer but fewer sessions compared to 35 (37.2%) who wanted shorter but more sessions. Sixteen people (17.0%) had no preference. Twenty-two people (23.4%) suggested other ways to receive the information with six requesting a website to complement the course. Amongst other things emails, practice staff and leaflets were also mentioned.

3.6 Barriers to attending a course

Participants were asked whether anything would prevent them from attending a course. One third of people (33, 35.5%) felt that nothing would prevent them. For the remaining people the main reasons were the timing of the course, illness, accessibility issues or work commitments. In terms of accessibility issues, eight people (8.6%) highlighted not having the course provided in another language or having no spoken language support or an interpreter available, not being physically able to access the building due to a mobility chair and for the participant who was

DeafBlind they would need a minimum of double the usual time for communication with a manual interpreter so felt that attending a course was not an option for them.

“I wouldn't go if they were only available in the evenings”.

“I rely on a DeafBlind manual interpreter. I need a minimum of double the usual time for communication. I would not be able to join in group sessions”.

3.7 Encouraging people to attend a course

Fifty-eight people (61.7%) suggested ways to encourage people to attend a course in the future. The main suggestion, mentioned by 22.4% of people (13) was to stress the seriousness of the condition within the letter or during discussions with practice staff. Nine people (15.5%) felt that the benefits of the course needed more emphasis, six HAREF participants (10.3%) felt that proactively telling patients that there would be language support available would encourage black and minority ethnic communities to attend a course, five people suggested having the course endorsed by previous attendees and four suggested emphasising the fact that you can recover or get better.

“Well, since I've been diagnosed I have to say I don't feel any different so for people like me I think they'd maybe need a shock to make them go on it - a leaflet explaining the things that could happen to you if you don't look after your diabetes”.

“I work in a shop a couple of days per week and when I was diagnosed with diabetes I was devastated. I was absolutely terrified of going blind. People who come in the shop were asking how I was and when I told them, they would just say 'oh, don't worry, it's just diabetes'. That's the problem - you need to get through to people how serious it is and make them realise it's not 'just' diabetes”.

3.8 Other comments

A number of people commented that they were looking forward to attending the DESMOND course, one participant requested a more personalised dietician session which took into account their other conditions and one requested a print out of their blood test results. Four people requested things around prevention that the health service could do; one wanted testing kits to be distributed to people to test themselves, one felt they should have been warned by their GP that they were at risk of developing the condition and two people who had been borderline for a length of time felt that they should have been offered a course around prevention.

“I would like to have been offered the course sooner, i.e. before I actually got diabetes as I had three years of being borderline and I could have tried to do something about it through diet if I had had the information. - I had been following a Slimming World diet where you ate loads of carbs which I think didn't help!”

“Why wasn't I given all this information when I was told I was borderline diabetic? This course would have been even more useful a year earlier when I was told I was borderline diabetic. Then I could maybe have

prevented becoming diabetic”.

4.0 Recommendations

4.1 Key recommendation

4.1.1 Recommendation 1: Preferred option

In terms of participants' preference for an education course, 49 people (52.1%) stated that they would choose option 2 if they were to attend in the future compared to 34 people (36.2%) who would choose option 1 and nine people (9.6%) who would choose option 3.

It is recommended that:

- If only one course format can be offered to patients in the future, consider providing option 2. However it must be noted that in terms of option 3, the cohort of people we spoke to was older people; we did not speak to anyone 34 or under and nearly two-thirds were 65 and older. Therefore, this option may have been more preferable to a younger age group.

4.2 Diagnosis

4.2.1 Recommendation 2: Diagnosis information

Thirty-two people (34.0%) suggested information they would have liked to receive at their diagnosis to enable them to start making immediate changes to their lifestyle and five people had difficulties accessing the information.

It is recommended that:

- Patients receive some more detailed information they can take away from the consultation around diet so that they can start to make changes straightaway before seeing a dietician or going on a course. This should include the best foods to eat and cut out, how to understand food labelling and some example recipes taking into account the sorts of food that people cook across communities. This information should be appropriate to the patient taking into account their level of English and any disabilities they may have.

4.3 Education courses

4.3.1 Recommendation 3: Accessing the course

One D/deaf participant had to wait eight months to get onto the course due to interpreter booking/fee issues.

It is recommended that:

- The appointment system for booking onto a course is flexible enough to take into account people who may need extra support to attend, ensuring that there are no delays for anyone accessing the course.

4.3.2 Recommendation 4: Course accessibility

Several participants requested access to BSL interpreters, spoken language support and information provided in Plain English with visuals. One participant felt that the course leaders should also have deaf awareness training.

It is recommended that:

- Any course takes into account the accessibility needs of all patients to ensure that everyone can attend a diabetes course if they wish

4.3.3 Recommendation 5: Course management

One D/deaf participant felt strongly that the course should focus on imparting facts and not the sharing of attendees' experiences as this resulted in the session they attended running over and their interpreters having to leave before all the information had been given out.

It is recommended that:

- Sessions are strictly managed in terms of timings to ensure that all attendees have the opportunity to gather all of the information on offer.

4.3.4 Recommendation 6: Course location

Participants were asked generally what their preferences would be for a course location 53 people (56.4%) requested a community location compared to 18 people (20.5%) who would prefer a hospital based course and 19 people (21.6%) had no preference.

It is recommended that:

- Courses be offered at community locations.

4.3.5 Recommendation 7: Course times

Participants were asked generally what their preferences would be for course times. Twenty-five people (26.6%) would be happy to attend a course during the daytime, 14 (14.9%) would prefer mornings, 11 (11.7%) afternoons and weekdays were requested by eight people (8.5%). In addition, when asked about barriers to attending a course, the timing of it was an issue for 10 people (10.6%) and others said it would depend on other personal or work commitments.

It is recommended that:

- Patients are offered a selection of course times, either during the mornings, afternoons or evenings to enable them to attend a course.

4.3.6 Recommendation 8: Course duration

Participants were asked generally what their preferences would be for the course duration. In contrast to the preference for Option 2, people would prefer longer but fewer sessions. Forty-one people (43.6%) requested this option compared to 35 (37.2%) who would prefer shorter sessions over a longer period although it must be noted that the difference in numbers is marginal.

It is recommended that:

- Consideration is given to the optimum duration of the course and length of session times. It is suggested however that session times should possibly not be as long as three hours or if this length of time is chosen, ensure that there is a break and refreshments available for attendees.

4.3.7 Recommendation 9: Course content

Participants were asked what they would like to learn from a diabetes education course. Numerous suggestions were made but those mentioned by at least ten percent of people were mainly around diet (40 people, 50.0%) followed by how to

manage the condition (10 people, 12.5%) the same information as was given on the DESMOND course (nine people, 11.3%) and how and where to exercise (11.3%).

It is recommended that:

- The course content is examined and if deemed necessary, some additional information be provided around diet, management of the condition and appropriate exercises to do and where to go to do them. In particular, what foods they can and cannot eat and in what quantities, food labelling and the glycaemic index, again taking into account the sorts of food that people cook across communities.

4.3.8 Recommendation 10: Support once the course had ended

Thirty-six people (38.3%) requested leaflets, 12 people (13.8%) requested a manual, 11 people (11.7%) requested access to a telephone helpline and 11 people (11.7%) requested follow-up sessions once the course had ended. In addition, 11 participants who had attended the DESMOND course requested additional support or information once the course was over in the form of follow-up sessions to check progress of attendees and top-up messages about diet changes and where to go to exercise. Six HAREF participants respondents requested that this follow-up take place within their community-based groups (where other family, friends or community members could attend) and within a year of attending the course. In contrast, none of the seven people who attended the LWTC which has ongoing support in the form of a buddy, requested any additional support.

One D/deaf participant asked about the availability of support groups and although there is one operating in the city, they were informed that there was no funding to help them access the group. Furthermore, when asked what changes participants would like to the course they had chosen, a further two people requested follow-ups and nine people requested online information to support the course from a trusted source that they could refer back to.

It is recommended that:

- Patients receive some form of support once the course is over but in particular consider providing:
 - Leaflets
 - A manual that they can work through or refer back to
 - A helpline
 - Some form of follow-up session provided about a year after attendees have completed the course to see how they are progressing and offer refresher information in a community setting.
 - The buddy system used by LWTC.
 - Support groups for attendees to access after the course or if this is not possible, ensure attendees are given up-to-date information about how to access groups in the community.
 - An online website to accompany the course and act as a reference point.

If these suggestions are not viable ensure that attendees have, at the very least, a contact number to call in case they have any queries about the information they have learned on the course.

- Consideration is given to how those requiring extra support to attend a group are able to attend community-based support groups.

4.4 Encouraging people to attend the course

4.4.1 Recommendation 11: Methods of encouragement

Fifty-eight participants (61.7%) made suggestions about what might encourage people to attend an education course. Thirteen people (22.4%) felt that the seriousness of the condition needed more emphasis, nine people (15.5%) felt that the benefits of the course needed to be more clearly advertised and six HAREF participants (10.3%) felt that proactively informing people that language support will be available would also encourage people to attend.

It is recommended that:

- Any information about education courses emphasises the seriousness of the condition and in particular how not managing diabetes can lead to deterioration of eye sight and feet problems. The benefits of the course should also be emphasised more clearly as should the availability of language support.

4.5 Prevention

4.5.1 Recommendation 12: Preventing the disease

Four people (4.3%) made suggestions around preventing the disease – distributing testing kits to patients, informing patients in advance that they made be at risk of diabetes and offering borderline patients the opportunity to attend a course around prevention.

It is recommended that:

- Although only four people had issues around prevention it is felt that any actions around this would have a noticeable impact on people developing diabetes in the city. Therefore, it is recommended that patients at risk of developing diabetes are offered the opportunity to attend a preventative course. If a course is not a feasible option, these patients should be given information about how to prevent themselves developing the condition.