Walsall Together Patient Engagement

Diabetes Care Pathway: Intelligence Report August 2020

Report Foreword

1. This report is the culmination of engagement work undertaken and co-ordinated by Paul Higgitt, Senior Engagement Lead, Healthwatch Walsall from the beginning of 2020 when individual patient stories were recorded followed by three virtual patient engagement events held during June and July 2020. This work has been supported throughout by Phil Griffin, Walsall Together Service User Group Chair. A significant number of diabetes patients have been involved in this work and there has also been some input from Diabetes Specialist Nurses and also Diabetes UK.
2. The report is the first of a series which will be completed as part of a Walsall Together user engagement user project which Healthwatch Walsall has been commissioned to carry out (5 others will be completed during the life of the project including for example cardiac and respiratory care pathways).
3. The report is in 2 parts:
    a. Summary report with key findings and recommendations – pages 2 to 5 inclusive
    b. Appendices to the report which include the notes of the virtual workshops held in June and July 2020 and individual patient stories – pages 6 to 19 inclusive
4. Healthwatch Walsall, many patients and members of the Walsall Together Service User Group want to see commissioners and providers of health and social care, to act in a demonstrable way to the intelligence provided via this report and the specific recommendations which are summarised below in this foreword and again in the report at Page 5. It is only by tangible and measurable improvements made, can it be said that the principle of co-production of care pathways is being achieved in Walsall and that the words in the Walsall Together terms of reference which are based on strong partnerships and working together with service users are not just rhetoric.
5. The recommendations applicable to the Walsall Together Tiered Model of Care are as follows:
    I. Development of a Diabetes Peer Support Group for people to share experiences and aid in supporting people around loneliness – **Tier 0**.
    II. More information and promotion of the IAPT / Talking therapies service for people with long term health conditions and in particular during the COVID-19 pandemic – **Tier 1 & 2**.
    III. Enhanced grass roots communication within the BAME communities around diabetes care and advice and reassurance of service delivery around diabetes and the impact of COVID-19 on BAME communities - **Tier 0,1,2.**
    IV. Ensure that there is consistency of diabetes care across General Practice during this challenging period that patients are accessing their essential check-ups – **Tier 1**.
    V. More joined up communication with the patient around early intervention, pre diabetic support, what is the general offer for the patient – **Tier 0,1,2.**

Phil Griffin- Walsall Together Service User Group Chair

Paul Higgitt- Senior Engagement Lead, Walsall Healthwatch

Walsall Together Patient Engagement

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1. Introduction

Walsall Healthcare NHS Trust and care system partners are developing new integrated ways of working to improve the health and wellbeing outcomes of their population, increase the quality of care provided and provide long-term financial sustainability for the system. Strong public and patient engagement are a key component of the transformation agenda including the co-design and implementation of the detailed service changes required.

Walsall Together has identified long-term conditions pathways for service redesign improvement work through a combination of needs analysis (Joint Strategic Needs Assessment) and partner strategic priorities.

Healthwatch Walsall is commissioned by Walsall Healthcare Trust as host provider for Walsall Together, to deliver the engagement work necessary for co-production of the identified priorities for service redesign.

Walsall Together has identified six priority care pathways through a combination of needs analysis (Joint Strategic Needs Assessment) and partner strategic priorities. The priority pathways are:

- Respiratory
- Diabetes
- Cardiology
- End of life
- Mental Health Outpatients
- Healthy child programme

1.2. Virtual Engagement

In order to secure improvement in these pathways a key principle is that improvement is the result of care professionals and patients working together so that care pathways are co-produced and are better understood and navigated by patients to achieve optimal care in the right place, at the right time by the right people.

March 2020, we had made positive links with partner organisations to engage directly and we had been building opportunities to engage with patients and clients in many different ways. However, due to COVID–19 we have had to look at new ways of working differently to ensure the project continued to move forwards. We considered a different approach to engagement forums that was based on using virtual technology such as Microsoft Teams or Zoom. In the end and after internal consultation the project got the go ahead from our IT people to proceed using Zoom as the platform to support virtual forums.

1.3. Living and Managing with Diabetes

Following on from our Living and Managing with a long-term health condition survey our focus during the last quarter has been on capturing the views of service users living and managing with diabetes and other related long-term health conditions.

We have been able to undertake this work through a series of 3 virtual workshops and capturing patient stories individually. Through June, July and August, we have been able to capture the views of more than 60 service users.

Below are the key questions that we have guided the conversations during the workshops:

1. Welcome and Introductions
2. Purpose of the meeting – Overview
3. Discussion Points:

    a. Do you understand Diabetes and how it impacts on your health?
    b. What is working well in helping you manage your condition?
    c. Have you been able to get the right checks such as your HbA1c, retinal check, podiatry checks etc? Any concerns over prescriptions?
    d. Have you been able to seek the right advice from the community diabetes team and how have you been supported?
    e. What could be delivered differently to support you. Could there be different ways of working?

4. Summary of Discussions
5. Views on the Meeting
6. Any Other Business

1.4. Summary of Workshops – Service User Comments

Key points from the 3 diabetes workshops:

- Very positive views around the community diabetes team and podiatry support. In that if you are known within the community diabetes team, access and guidance is positive.
- Impact on mental health and need for support for people with diabetes. Some service users have felt a sense of loneliness and impact on mental health which has been exacerbated due to COVID-19. However, of those we have spoken to very few were aware of a referral system into Diabetes and Talking Therapies.
- Many service users have informed us that they would like to see a Peer support group established even virtual (Healthwatch Walsall are looking to support development of a Diabetes Peer Support Group in conjunction with Diabetes UK).
- Commonalities in relation to poor access to information around diabetes around nutrition and appropriate eating unless known to the service was highlighted. Where do people go for support and general advice on nutrition and health.

- Diabetes UK also attended the workshops and shared their information on their 15 healthcare essentials. https://www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes/15-healthcare-essentials/what-are-the-15-healthcare-essentials. Some service users are aware of the checks undertaken as part of the Diabetes and Me programme however a number of service users were not aware of the full health check list and that is was not consistent.
- We were able to engage with a representative and service user from BAME communities, who informed us of the impact of diabetes and COVID-19 and the need for grass roots information on support offered. Focused information and support at those at most risk.
- Some comments from people from Asian communities – lack of understanding around nutrition and what is said to people in relation to advice. Some Asian people cannot read and write in own language. Not enough talking within communities around the condition. Feel they go to the GP and many patients' concerns seem to be put down to diabetes. It was also highlighted that it does not matter what ethnic group you are from all patients need to be able to access the same information.
- Ensuring access to better access to information around medication management for some services users.
- Many people have found the Diabetes awareness course very informative but need to have opportunities for further follow up with dietitians. We were informed that not all service users had been referred to the courses and for those who were not newly diagnosed would be interested in attending, even if this were virtual during these challenging times.
- It was questioned who co-ordinates the pre diabetic referral. It is not clear to all patients. NHS pre diabetic support noted through public health, but awareness is not consistent. It was felt that not all GP practices refer into this service.
- Clearer support offered to manage diabetes and heart conditions (particularly around circulation). Community diabetes team have been very helpful but still awaiting a referral to Cardiology.
- Not all service users were aware that for vulnerable clients during these challenging times there are home eye screening service available such as through https://oncallopticians.co.uk/ (other providers may be available).
- Although there were many positive comments around service provision there were comments that about whether the Community Diabetes Team, NHS pre diabetic checks, Walsall Public Health prevention initiatives and Diabetes UK providers work in conjunction with each other.

1.5. Summary

Whilst this report is based on the feedback from 60 service users and with an increasing prevalence of Diabetes T2 in Walsall there are some consistent comments from those who participated. These are mainly focused on consistency in communication through GP's, access to the right information and support at the right time and the impact of mental health and loneliness for service users with diabetes.

1.6 Recommendations

As part of service users care pathways, we have identified which tier of the pathway where people have identified they would like changes in care delivery to take place:

Tier 0	Building on Resilient Communities
Tier 1	Primary Care and Long-Term Conditions
Tier 2	Specialist Care
Tier 3	Unplanned
Tier 4	Acute Care

Development of a Diabetes Peer Support Group for people to share experiences and aid in supporting people around loneliness – **Tier 0**.

More information and promotion of the IAPT / Talking therapies service for people with long term health conditions and during the COVID-19 pandemic – **Tier 1 & 2**.

Enhanced grass roots communication within the BAME communities around diabetes care and advice and reassurance of service delivery around diabetes and the impact of COVID-19 on BAME communities - **Tier 0,1,2.**

Ensure that there is consistency across GPs during this challenging period and that patients are accessing their essential check-ups – **Tier 1**.

More joined up communication with the patient around early intervention, pre diabetic support, what is the general offer for the patient – **Tier 0,1,2.**

Appendices

1. **Diabetes Workshops Notes**
2. **Patient Stories**

Appendices 1. Diabetes Workshop Notes

Notes/Actions from the Walsall Together – Living and Managing with Diabetes Workshop 11am, 11th June 2020, Virtual Zoom

Discussion Points

Question 1
Do you understand Diabetes and how it impacts on your health?

1.1 Comments from Patients/Service Users
1.1a Information/Sharing Information

- Have never had anything from Walsall Diabetes.
- Diabetes UK information on their website is very good.
- I am treated at another hospital out of the Borough for another condition, but the information is not shared between Trusts.
- I have been diabetic for 30 years. The only information I get is from searching the internet. I need to know where to go and get advice from for feeling better and eating the right food.
- I have been on the same medication all the time.

1.1b Impact and Support for Mental Health

- Type 1 Diabetes for 16 years. Not enough support for the mental health impact. I was not told it could affect your mental health.

1.1c Diet Information

- There is lots of information of what we should eat, but no information of consequences if you do not stick to the diet.
- I got to the Pulmonary Rehab. Clinic in Walsall. They often have a Diabetes Professional attend who gives advice on diet. I am dual heritage and would like some more information on this diet.
- It was noted Walsall NHS Trust offer a course for people who have diabetes. These take place in the Community and last for 6 weeks per course.

Question 1 Response / Action required from WT

- More information about local services should be disseminated and be widely available.
- 15 Healthcare Essentials information (produced by Diabetes UK) to be distributed to all attendees at the Diabetes Workshop.
- Investigation to be made if all GP's have got a copy of the 15 Healthcare Essential leaflet.
  **15 Healthcare Essentials is the minimum standard of care a Diabetes patient should receive.*

Question 2
What is working well in helping you manage your condition?

2.1 Comments from Patients/Service Users

2.1a Information

- Self-taught management due to lack of advice from Professionals.

2.1b Podiatry

- Foot care is a good service at both Pinfold and Walsall Manor.

2.1c Eye Tests

- Eye tests – screening once a year. Opticians undertake home visits to some vulnerable residents.

2.1d Specialist Diabetes Nurse attending some GP Practices

- Diabetes Specialist Nurse visits the surgery and '*it really works, and I can even email her'*

Question 2 Response/Action required from WT

- It was noted the service offered by Diabetes Specialist Nurses is very good. However, getting access to these services is a problem.
- Action required to see if Opticians will visit Care Homes and undertake home visits if people are shielding due to Covid-19.

Question 3
Have you been able to get the right checks such as your HbA1c, retinal check, podiatry checks etc? Any concerns over prescriptions?

3.1 Comments from Patients/Service Users

3.1a Access to blood test and HbA1c

- HbA1c was due in March 2020, but I have not had it due to being in the shielding category for Covid-19. It was noted Heartlands Hospital are carrying out blood tests via drive thru.
- Some patients can go to their GP Surgery to have blood tests.

3.1b Prescriptions

- An example was given whereby 2 Community Nurses had always visited a vulnerable lady's home twice a day and had administered her insulin. With no notice she was asked to get the prescription. We did not know how much to order or when.
- At the start of the Covid-19 another patient had their insulin increased for 2 months. Twice she has run out of insulin.
- Type 1 Diabetes - Another diabetes patient said she must test her blood sugars up to 8 times a day. She needs a large supply of the kits to test but this is always a struggle with her GP when she requires a prescription.

Question 3 Response/ Action required from WT.

- Communication – Pharmacist GP and Patient communication and access to medication.
- Engagement Lead is to raise the question of insulin shortage with the Medicines Management Team at Walsall CCG.

Question 4
Have you been able to seek the right advice from the community diabetes team and how have you been supported?

4.1 Comments from Patients/Service Users

- Could do with more support in GP practices for help/information on diabetes. A patient had been living with diabetes for 30 years and nothing had been offered to her. No one explains the medicine to her.
- Learning Disability diabetes patients do not receive any support.

Question 4 Response/Action required from WT

- Diabetes Specialist Nurse confirmed every GP Surgery should offer the 6-week Education Programme offered by The Diabetes Team.
- Diabetes Specialist Nurse said they would be able to offer support to patients with Learning Disabilities in small groups. They take into consideration each patient individual needs. Patients can be referred via their GP.
- Diabetes UK Regional Director Midlands and East – Diabetes UK offer a course 'Living with Diabetes Days'. It was suggested Diabetes UK work with Walsall Together and factor into their programme Living with Diabetes Days. These maybe online now due to Covid-19.
- Diabetes UK is in the process of working on online modules, which should include easy to read.

Question 5
What could be delivered differently to support you. Could there be different ways of working?

5.1 Comments from Patients/Service Users

5.1a Communication and Organisation – District Nurses
It was noted when District Nurses visit patients to administer insulin/medication that they do not arrive at set times. This makes it difficult when trying to ensure a patient has eaten/not eaten. There previously had been different information about whether the patient should eat before the insulin or after. This has now been sorted but it took a group meeting to agree.

Question 5 Response /Action required from WT
Communication/organisation from District Nurses were noted.

6. **Summary of Discussions**

- Consistency through ALL GP practices in supporting patients with Diabetes and other associated health conditions.
- Relating to inconsistency in services Diabetes UK said that they were able to attach a small card with the 15 Healthcare Essentials to over a 100, 000 prescriptions in the Birmingham and Black Country.
- Support for Learning Disabilities in terms of information.

- Medication access and reviews and administration information particularly during Covid-19. Access to insulin through this time is a challenge for some patients.

7. **ACTION**

Service Users would like to see Walsall Together partners to map what is provided around ALL GP's in Walsall.

Notes/Actions from the Walsall Together – Living and Managing with Diabetes Workshop 11am, 17th June 2020, Virtual Zoom

Discussion Points

Question 1

Do you understand Diabetes and how it impacts on your health, do you have adequate information?

1. **Comments from Patients/Service Users**
    - Mixed comments were received from service users. Some patients had access to a lot of information and support from their GP practice and had been offered a 6-week diabetes course.
    - One diabetes patient had been diagnosed with diabetes 12 months ago. He was given tablets by his GP and has not had any information since.
    - It was noted service users often use the internet to find information.
    - One patient has Type 1 Diabetes and said the only issue she has is that everyone, including her GP presumes she has Type 2 diabetes.

1.2 Summary/Points to note from Question 1
No consistency between GP practices in terms of information and communication.

Question 2
What is working well in helping you manage your condition?

2.1 Comments from Patients/Service Users
- Eye screening seems to be working well. A discussion was had over the time of day the service users have their eye screening. The eye dilation procedure can make it difficult to see for a while after and some patients must go back to work.
- One patient noted that they have had no input from the clinical side at all in helping him manage his condition.

2.2 Summary/Points to note
- In terms of Eye Screening appointment times it was noted many opticians are flexible and will change times. It is more difficult to change appointment times at the hospital for Retinal Screening.
- Who should be proactive the patient or the GP?

Question 3
Have you been able to get the right checks such as your HbA1c, retinal check, podiatry checks etc? Any concerns over prescriptions?

3.1 Comments from Patients/Service Users
- Some patients have had medication reviews/analysis which resulted in simplifying and re-organising the whole process.

- One service user from another GP practice said the only checks he has is a blood test every 3 months. He does not have any Podiatry checks. His HbA1c results were taken at the hospital in relation to his kidney disorder.

3.2 Summary/Points to note
It was noted that some GP practices seem to be more proactive than others.

Question 4
Have you been able to seek the right advice from the community diabetes team and how have you been supported?

4.1 Comments from Patients/Service Users
One service user said they were happy with the service; she can phone her surgery and they book her in with the Nurse. However, said this is become she is known to the community diabetes team.

4.2 Summary/Points to note from Question 4
The Community Specialist Diabetes Nurse confirmed if patients contact their surgery, they can book you in with the Specialist Diabetes Team. There are 5 Nurses in the team. The Team refer to specialists such as Dieticians and Podiatrists. Due to Covid-19 telephone consultations are taking place, these have worked well. Urgent blood tests are being done and as a result the Diabetes Team are getting referrals.

Question 5
What could be delivered differently to support you. Could there be different ways of working?

5.1 Comments from Patients/Service Users
It seems there is an excellent service available, but communication to the patient is just not there. Why has Little London Surgery been able to support their patients whilst others are not?

5.2 Summary/Points to note
- Communication and consistency among all GP practices is vital. Without communication and information, inequalities can arise.
- If the community diabetes team provide services and public health are providing support and Diabetes UK do these services join up their work.

2. Summary of Discussion - Questions 1 -5
1. Need consistency of services in Primary Care Networks.
2. Access to information and communication and services needs to be addressed as this varies across GP practices.
3. Need to address the differences between Type 1 and Type 2 Diabetes and peoples understanding.

3.Views on the Meeting
Attendees agreed the Workshop was a good idea and very useful.
Action: Thanks to be extended to Little London GP Practice for their support to patients with Diabetes.

Notes/Actions from the Walsall Together – Living and Managing with Diabetes Workshop

11am, 9th July 2020, Virtual Zoom

Discussion Points

Question 1

Do you understand Diabetes and how it impacts on your health, do you have adequate information?

1.1 Comments from Patients/Service Users

- One patient informed the group she had been diabetic for many years, as she is getting older it is harder to control.
- Due to the Covid-19 lockdown it was noted some patients had/are experiencing depression and anxiety and fear.
- Diet and Nutrition advice - A concern was raised by some patients who felt they needed more support and advice for diet and nutrition. One patient has been pre diabetic since 2009 '*I have never had any training on diabetes in what I can and eat or not eat. I went on a one-day course a few years ago'*
- The question was raised '*Is there any advice/guidelines for people who are BAME and Diabetes?'*

1.2 Response from Professionals to Question 1

- Diabetic Nurse informed meeting members a **'Diabetes and Me'** course was now available (accredited by Wolverhampton University). It is available to newly diagnosed diabetes but can be used as a refresher course.
- **Emotional Support** - Diabetes UK have information on emotional health on their website. You can find out more by clicking the link: www.diabetes.org.uk/guide-to-diabetes/emotions
- **Talking Therapies** is also available in Walsall for emotional support. Patients can self-refer; they will be classed as a priority due to them having diabetes. **Telephone 0800 953 0995**. They will do initial assessments over the telephone and will offer a series of appointments via the telephone.
- **Diet and nutrition** – **One You Walsall** offer Lifestyle Courses.
  Telephone: 01922 444044 or **www.oneyouwalsall.com**
- Public Health are in the process of setting up '**Love Food, Love Life'**. Simple recipes will be available online. They are looking at doing healthy cooking sessions via Zoom 'Open up your Kitchen Cupboard'
- '**Love Food Enjoy Life'** for Cardiovascular patients is also in the process of being developed. If you are interested in joining a cooking session with **Love Food, Enjoy Life** send your details to goodfood@consultant.com or call **07545 180 103**, register your interest and they will get in touch about sessions.
- **NHS Diabetes Prevention Programme** – Available to people who are pre-diabetic. Service Users are encouraged to speak to their GP to access this course.
- **Diabetes UK has an online learning tool**. **Zonehttps://learningzone.diabetes.org.uk/** It offers a deeper dive into the basics of managing diabetes, with quizzes and videos,

all tailored to the type of diabetes a patient may have. People need to register using their email address. Using the tool has helped people to keep their blood sugars in range, reduce the risk of complications, boost diabetes confidence, look and feel healthier.

- **Diabetes UK – Peer Support Group**. These are currently being run by Diabetes UK in other areas of the country. Diabetes UK will support and train people in Walsall to become a Volunteer and lead a Support Group for Walsall Residents.
- BAME – Guidelines are being drawn up by Public Health.

Question 2
What is working well in helping you manage your condition?

2.1 Comments from Patients/Service Users
Concern was raised by one diabetes patient that he does not get reminders about blood tests anymore. It was noted that some patients were proactive and phoned the GP Practice.

Question 3
Have you been able to get the right checks such as your HbA1c, retinal check, podiatry checks etc? Any concerns over prescriptions?

3.1 Comments from Patients/Service Users

- One patient expressed concern that she has not had her HbA1c checked. She was advised by the Diabetes Nurse to contact her GP Practice.
- One patient informed the group he had not heard nothing from his surgery. He had a message to say he was due for some checks; he completed the questionnaire but has heard nothing since.

Question 4
Have you been able to seek the right advice from the community diabetes team and how have you been supported?

- Diabetes Team - Contact telephone: 01922 604970, based at Bentley Health Centre.

Question 5
What could be delivered differently to support you. Could there be different ways of working?

5.1 Comments from Patients/Service Users

- Surgeries need to be informed more about diabetes.
- More advertisement - Seems to be lack of information of where to go. You cannot find an easy answer. Many diabetes patients research the internet, but this is not an option for everyone.

Response from Professionals to Question 5
Information on Diabetes UK website is available in different languages.

2. Summary of Discussion - Questions 1 -5

Peer Support Groups – Need to get these running as these will the address information and communication concerns. Diabetes UK has offered their support to get the project of the ground.

Overwhelming issues around mental health, loneliness, depression – Peer Support groups will help alleviate these issues

Appendix 2

Patient Stories

Walsall Together – Living and Managing with Diabetes
Patient Story – Date: 26 June 2020

Patient name: M
Postcode: WS8, Aldridge
Age: Over 70
Ethnicity. British White

Current Health Conditions:

- Diabetes Type 2 – controlled with diet and exercise.
- Arthritic hips and knees.
- Peritoneal cancer – Under Consultant at Heartlands Hospital.
- Prostrate problems.
- High blood pressure.

Waiting for a dynamic Lymph node biopsy of the groin. This has been delayed due to Covid-19.

When were you diagnosed with Diabetes Type 2?

I was diagnosed at being at risk in 2005 but this was never followed up. In 2007 I had another Wellbeing check where I was diagnosed as having Type 2 Diabetes. My diabetes is controlled by diet only.

What Health Services do you use?

Diabetes Nurse

I regularly see the Diabetes Nurse at my GP practice (Anchor Meadow, Northgate, Aldridge) I saw the Diabetes nurse in January 2020 and since had a telephone consultation.

GP Practice regular blood tests

I had a blood test at the end of May 2020 at my GP Practice. I had to wear a mask. I felt relieved to have the test as it is difficult to see how you are doing when you control diabetes with your diet.
I have the email address of my nurse and she emails me the results.

What Health Services do you use contd.?

Eye Screening

I get a standard call every year and will have my eyes screened.

Podiatry

I go to a private chiropodist every 3 months. I have been during Covid-19. They took my temperature beforehand.

What motivates you to take your diabetes seriously?

Two things motivate me:

- I found out you could reverse diabetes.

- I do not want to go on medication in the form of tablets or insulin.

Before Covid-19 is there anything that you feel could be improved?

Access to a Dietician

I am having trouble in controlling my diabetes and at the same time maintaining a reasonable weight, it fluctuates.
I have asked for an appointment with a Dietician. I have been told they are not making appointments now due to Covid-19. I need their input to give me some advice.

Exercise Programme

I was member of the PACE programme. I attended regularly, it really helped me.
Unfortunately, the scheme closed August 2019.

Diabetes Support Group

It would be great if there could be a Diabetes Support Group, where diabetes patients could share experiences and support each other.

Patent Name. PT
Postcode. Bloxwich
Age. 56
Ethnicity. British White
GP Practice. Pinfold Medical Practice

Type 2 on Insulin Diagnosed around 25 years ago, Insulin for last 23 years + Metformin and Empagliflozin (recommended by Podiatry)

Purpose of the meeting – Overview

Discussion Points:

Do you understand Diabetes and how it impacts on your health?
Generally, yes though tricky to keep track of subtle differences and decline on health.
Do we need to test before every journey by car when driving?

What is working well in helping you manage your condition?
Change of Long Acting Insulin to Tresiba – BUT harder to manage than previous type (Lanctus) with the effects of warmer weather (increased Hypo Symptoms) and COVID = decline in activity.

Have you been able to get the right checks such as your HbA1c, retinal check, podiatry checks etc? Any concerns over prescriptions?
All were reduced during COVID – Changes at GP surgery often hard to get through by phone and the econsult did not have “diabetes” as a topic. Suggest an app/link for diabetic questions.
Podiatry Checks were first to restart but one day notice for appointment and gave no guidance about COVID measures required. Having said that I felt much safer than expected and the treatment was excellent. However, the need to have an operation is on hold due to my relatively high H1bAc result

Have you been able to seek the right advice from the community diabetes team and how have you been supported?
Recent staff change and lack of access to online system affected face to face appointment. My recent HbA1c results were disappointing given the routine test results were showing a great improvement but hard to explain why my results did not match the HbA1c figures.

Suggest an alternative method of tracking blood sugar closely for week before consultation.

What could be delivered differently to support you. Could there be different ways of working?
I have learned much about my Diabetes over the years but found it really hard to manage weight and implement exercise. Knowing what to do and the lack of motivation/drive to implement is needed.

I find keeping accurate diet, pre and post meal test results in order to give the medical team information quite daunting.

Patient name: A
Postcode: WS5, Bescot
Age: 63
Ethnic Group: Asian/ British
Gender: Female
GP Practice: The Pleck Health Centre

1. **What are 3 Main Health Conditions that affect you most?**

- Arthritis
- Cardiology - Heart Triple Bypass
- Type 2 Diabetes - diagnosed 2 years ago (2018)

2. **How do you manage your Diabetes?**

- Metaform – Smallest dose

3. **Do you receive regular Health Checks?**

- Eye Test every 12 months.
- Have not been offered any Podiatry checks.
- The family must contact the GP Practice if we want a blood test.

4. **Do you have access to a Diabetes Specialist Nurse?**

- No – I have never been told about the Diabetes Specialist Nurse.

5. **Are there any services that you use which could be delivered differently?**
Communication

My mum attended a Diabetes workshop when she was first diagnosed with Diabetes. The workshop was for people who did not speak English as their first language. I went to the workshop with mum to support her. I ended up translating, as the course was mainly delivered in English.

Appointments to see professionals are arranged with those that can speak another language but when we arrive for the appointment they often cannot translate. The speaker needs to be trained on patient engagement and speaking another language.

Nutrition/Diet Workshops

Nutrition workshop did not consider specific dietary requirements such as lactose intolerance, gluten free, vegetarian, or vegan. For example, it spoke about reducing carbohydrates, but a gluten person does not eat carbs.

The nutrition workshop does not also consider different cultural diets.

6. Would you be interested in attending a self-support group?

Yes, I would be interested in attending.

Patient name: H
Postcode: WS1, Palfrey
Age: 67
Ethnicity: Black Jamaican
Background:

H was diagnosed with Type 2 Diabetes at the age of 50. For the first 2 years her diabetes was managed by diet only. After 2 years H was put on medication.
H also has:

- Sickle cell Traits
- Thalassemia
- High blood pressure

Health Services currently used by H:

- Retinal screening at an optician twice a year.
- Podiatrist – every 6-8 weeks.
- Diabetes Nurse specialist every 6 months.
- Regular blood tests.

Current Medication

- Tablets
- Waiting for renal test to see if she must go on insulin.

Other information

- H is not a member of a Support Group. She would like to meet people who have diabetes.
- GP Surgery – She is very happy with the service she receives from Little London Surgery.
- She cares for herself and does not get any help from any other services.

Patient name: Jenny – named changed.
Postcode: WS2, Bentley
Age: 47
Ethnicity. Dual Heritage

Background.
In 2011, at the age of 38, Jenny became very unwell. After several tests and investigations, she was eventually diagnosed with Chronic Obstructive Airway Disease (COAD) and Bronchiectasis. Jenny has never smoked and has not been exposed to asbestos. The Doctor at Walsall Manor Hospital prescribed Jenny's medication and Jenny was under Walsall Manor COAD team.
Three years ago, Jenny was referred to Heartlands Hospital to start trial medication and was also diagnosed with Silica Asthma. Jenny is still under Walsall Manor COAD specialist Team but is also receiving treatment including EPO at Heartlands.
Jenny takes a series of steroids including lifetime prednisone. These specific medications have now resulted in her having developed medically induced Type 2 Diabetes. Jenny was diagnosed with Diabetes, 2 years ago.

Referral to Community Diabetic Specialist Team.
Jenny's GP and Practice Nurse (St. Peters Surgery Walsall) tried to control Jenny's diabetes with medication in the form of tablets. After 12-18 months on tablets Jenny's GP practice referred her to the Community Diabetic Specialist Team. Jenny felt that the referral seemed to be quite late due to the severity of her diabetes.

Effects of Covid-19
Before Covid-19 Jenny saw the Specialist Diabetes Nurse every 4 weeks. She now speaks to Specialist Diabetes Nurse on the phone. Jenny was keen to point out the care has been exemplary.

Eye Tests
Over the last 18 months Jenny's eyes have deteriorated and during this challenging period continue to worsen. It is unclear whether she is required to have another retinopathy test. She would like an eye test so she can get a prescription for glasses. Because of her lung condition Jenny is in the highly vulnerable category and is therefore unable to go to an optician. There has been limited advice and Jenny is unclear if this can be done at home safely. She is extremely worried that her eye site is declining at a rapid rate.

HbA1c Test
This was due in February 2020. Jenny's GP said the District Nurses would not come to Jenny's home to do the blood test. This is still also outstanding.
Every 4 weeks Jenny has an injection of Mepolizumab administered by Heartlands Hospital. Because Jenny is significantly at risk she stays in her car with a mask on and a professional wearing appropriate PPE gives her the injection via her car window. She has asked the questions; Can Walsall NHS Trust offer such similar services for blood tests and in particular for those who are highly at risk. Although things may improve some people who are vulnerable do not feel attending a surgery or hospital is a safe environment and in Jenny's case, she is very unsure if this will be possible this year. Jenny also has been receiving pulmonary rehabilitation at Walsall Manor during this current situation.
She is concerned about when tests will be available, reassuring and safe for patients who are vulnerable.

What could be delivered differently to support you?
For Jenny and several people that we have spoken to with Diabetes, Jenny would like to attend Group Sessions where she can share her experience with others who have Diabetes. Keep talking, keep sharing. However, there are no peer support groups in Walsall around talking about diabetes.

Name. Brett (name changed)
Postcode. WS 2
Age. 58
Ethnicity. British White

Brett had type 2 diabetes. Around 7 – 8 years ago Brett was around 31 stone in weight and was finding things at work difficult and carrying out tasks painful.

Brett had struggled with his weight for many years. He had been informed that by the age of 55 he could be paralysed, and his life expectancy was potentially significantly reduced. He visited his GP at the Little London surgery and was referred to Walsall weight management team.

Brett lost 2 stone, but found it became difficult to lose more weight even though Brett had gone to Slimming World and Weight Watchers. Brett had the necessary health checks, such as thyroid function, and the weight management team could not identify any underlying health conditions that could be having an impact on this.

The weight management team had tried placing Brett on 5 different medications, but nothing seemed to be working, although he continued to diet. His body seemed to be retaining sugar.

“The weight management team at Darlaston tried everything - they were fantastic”.

Brett had a conversation with the weight management team and was referred to a consultant and psychologist to discuss various options available to him.

Two years ago, Brett had a conversation around three different types of Bariatric surgery. In November 2018 Brett had a Bariatric Sleeve procedure at Walsall Manor Hospital. Over the next 12 months Brett was fully supported by the community diabetes team and weight management team in relation to nutrition and exercise, and in November 2019 his weight was down to 19.5 stone. Around November – December Brett was informed that he was now pre-diabetic.

Through the diabetes team Brett continues to access all essential health checks and has his Hba1c checked regularly along with 12 months retinal checks.

The diabetes nurse has been very encouraging and has encouraged him not to drift. 12 months ago, the Diabetes nurse could not find a pulse in his foot during a podiatry check. Brett was quickly referred to Bentley clinic where a pulse was found, and he was reassured and given advice.

In 2019 Brett started to suffer from depression due to family circumstances. Brett explained his wife almost died due to a heart condition. Brett was finding things hard but did not want to go back to how things were, and for his weight to start creeping back up.

His depression was also picked up by his GP under a routine check as the GP was able to pick up the signs. Brett was referred by his GP to Walsall self-care management team for a 12-week self-care management course. Although at first Brett was apprehensive, he went on the 12-week self-management course which he found useful.

He said, “It gave me a kickstart to hear from other people some of whom have bigger issues than myself”. Whilst on the course Brett met up with a young gentleman who is deaf and cannot speak. They have built up a supportive bond and pre COVID – 19 they both went to Aqua fitness in Walsall, which has helped Brett tremendously.

Brett also has Atrial Fibrillation and has been taken into Walsall Manor several times suffering with dizziness and fatigue. After being checked over he has been referred back to his GP each time but is unsure whether the AF is a result of his weight / diabetes.

During COVID – 19 Brett has said that he has put around half stone on and really misses the aqua fitness and friendships. He is still committed to ensuring that his weight is under control, and that he finds the support he receives through the community diabetes team reassuring. “I cannot fault the care that I have received the Walsall NHS Trust”.