Understanding Type 2 Diabetes in Enfield

March 2026

healthwatch Enfield

Contents

Acknowledgements

We extend our sincere thanks to the local organisations, *Centre for Social Inclusion, One-to-One, Ordnance Road Methodist Church, and Sisters in Mind* for welcoming us into their spaces and enabling us to speak with their wonderful members, as well as the people of Enfield who participated in and promoted our survey.

We are grateful to the Community Outreach Diabetes Team at North Middlesex University Hospital for their collaboration and for attending our workshops to provide residents with vital education, advice, and information. We also thank Diabetes UK and Enfield Council for their guidance, support, and for providing valuable contacts and preliminary information.

Our appreciation goes to our student intern for their research contribution, and to the volunteers and staff of Healthwatch Enfield for their continued commitment to community outreach.

About Us

Healthwatch Enfield serves as an independent champion for local people who use health and social care services; we lend our ears to the Enfield community and represent their voice. We team up with multiple community organisations and statutory institutions to share information and gather insights in the aim to help improve the quality of health and social care services in the borough.

We share information and advice with residents to ensure they get the support they need, acting as a health and social care champion.

We gather feedback through projects, experiences shared by residents and community groups and social listening to share with public health and social care leaders and local decision-makers to help guide local policies and strategies.

Healthwatch is for everyone that uses all health and social care services, ranging from GPs to care homes, hospitals to pharmacies.

Introduction

Each year, Healthwatch Enfield conducts an annual survey to understand residents' views on local health priorities. In our annual priority survey of 2025/2026, Type 2 Diabetes (T2D) emerged as one of the top three priority areas, where many residents shared difficulties with managing and controlling the condition.

In response, Healthwatch Enfield launched an investigation to explore how awareness and education around T2D management and prevention can be strengthened for communities at higher risk.

Between November 2025 to January 2026, we carried out outreach to understand residents' awareness of T2D, their confidence in managing and preventing the disease, what resources they currently use and what services would help them. A total of 119 residents participated in the study.

This involved:

- **Workshops**: We delivered a series of interactive focus groups with community organisations representing groups at higher risk of T2D. These sessions captured lived experience and challenges, supported by expert input from Diabetes Specialist Nurses and a Dietitian from the North Middlesex University Hospital (NMUH) Community Diabetes Team, who provided education, guidance, and advice on managing and preventing T2D.

- **Online Survey**: An online survey gathered wider borough-level views on T2D. It aimed to understand residents' awareness, confidence in managing or preventing T2D, and experiences of accessing support, while reaching demographics often underrepresented in face-to-face engagement.

In line with the borough's Live Well Strategy to improve long-term condition management and prevent complications, this research explores barriers to accessing T2D care, strengthens service understanding, and captures residents' lived experiences to support early intervention and empower people to take control of their health.

Literature Review: The Scope of Type 2 Diabetes in Enfield

What is Type 2 Diabetes?

Type 2 Diabetes occurs when the hormone insulin does not work properly or when the body cannot produce enough of it. This leads to elevated levels of glucose (sugar) in the blood. The condition mainly affects adults but can also develop in children (NHS 2026).

Vulnerable Groups at Higher Risk of Type 2 Diabetes

The burden of T2D is not evenly distributed: it disproportionately affects certain ethnic groups, age, health problems, and socioeconomic statuses.

Older Adults

- Older adults are consistently identified as a group at significantly higher risk of developing Type 2 Diabetes, with prevalence increasing steadily with age.
- National data from the Government Diabetes Profile (2025 update) shows that most diagnosed cases of T2D occur in people aged 45 and above, with risk rising further in older age groups (Gov.uk 2025).

People Living in Deprived Areas

- Enfield's *Joint Health & Wellbeing Strategy (2024–2030)* highlights persistent health inequalities, noting that residents in the most deprived areas experience higher rates of long-term conditions, lower life expectancy, and increased poverty levels, all contributing to higher T2D risk (Enfield Council 2024).
- National evidence also shows a clear deprivation gradient in diabetes prevalence (Gov.uk 2025).

South Asian and Black Communities

- South Asian and Black African/Caribbean populations develop Type 2 Diabetes earlier and at higher rates than the general population, often 5–10 years earlier than White populations (Diabetes UK 2024).
- This pattern is mirrored locally, with high rates among Enfield's residents: South Asian communities in Enfield, the overall prevalence is 54.9%, including 19% among Bangladeshi residents and 17% among Indian residents. Prevalence is also high in Black African and Black Caribbean communities, at 37.98% (Public Health Enfield 2023/24).

Obesity and Sedentary Lifestyles

- *Enfield's Health & Wellbeing Strategy* identifies obesity as one of the borough's most significant health challenges, driven by inactivity, food affordability, and environmental determinants (Enfield Council 2024).
- Men (or those born male at birth) are at higher risk of developing T2D, because they carry more visceral fat and have more insulin-resistant adipose tissue, both of which strongly increase diabetes risk (Nordström et al. 2016; Diabetes UK 2024; Statista 2026; see glossary page 32).
- National data echoes that overweight and obesity remain dominant risk factors for developing T2D (Gov.uk 2025; Statista 2026).

The Impact of Digital Exclusion and GP Registration

- Populations not registered with a GP, those experiencing digital exclusion, and migrant or transient communities are at greater risk of being undiagnosed or receiving delayed support (Healthwatch Enfield 2025).
- Enfield Council identifies *thousands* of unregistered residents, which directly affects case-finding, early diagnosis, and access to diabetes prevention programmes (Enfield Council 2024).
- Digital exclusion also compounds inequalities, affecting access to digital referrals, remote monitoring, and online education materials (Enfield Council 2024).

Table 1 Existing Diabetes Prevention and Management Services in Enfield

Service	Description	Impact
Enfield Community Diabetes Service	Provides diabetes education, medication management, insulin initiation, hypoglycaemia management, specialist dietetics, neurovascular clinics, and community/home-based support. Also supports complex cases including steroid-induced diabetes, PEG-feed diabetes, and palliative diabetes care. Offers DESMOND/myDESMOND structured education and multi-channel delivery (telephone, home visits, face-to-face).	Increases access for vulnerable/high-risk residents; broad clinical support beyond education; enables self-management, early intervention, and reduces complications.
NCL Integrated System Approach	North Central London Diabetes & Weight Management Network coordinates primary, community, and specialist services across ICS.	Improves performance on treatment indicators and reduces variation in diabetes outcomes across boroughs.
Digital Eye Screening	NHS England's rollout of digital retinal screening and local eye scanning services that reduce need for hospital-based ophthalmology.	Enables earlier detection of diabetic retinopathy; reduces hospital burden and supports preventative care.
Blended NDPP Delivery	NHS Diabetes Prevention Programme (NDPP) provides 9-month behavioural change programme for adults at high risk of Type 2 diabetes, delivered via group sessions, digital apps, and personalised coaching. In NCL, delivered by Living Well Taking Control with digital partner Liva Healthcare.	Improves uptake among working-age adults; reduces progression from pre-diabetes to diabetes; supports weight loss and healthier behaviours.
Community Outreach & Inequalities Work (Enfield)	NCL ICS funds outreach programmes offering free blood glucose and blood pressure checks, culturally tailored sessions, translation-supported education, and engagement specifically in Somali, Turkish, Black and South Asian communities. Delivered in churches, hubs, and community settings.	Reduces health inequalities, increases screening uptake, builds trust, and improves early diagnosis among high-risk communities.
Peer-Led Support (Enfield Diabetes Support Group)	Monthly community support meetings with expert guest speakers, peer advice, education sessions, and emotional support for people with diabetes and carers.	Enhances self-management, provides emotional support, and complements formal clinical services.
Podiatry Services (Enfield)	Provides podiatry care for people at risk of diabetic foot complications, including foot risk assessments, monitoring of at-risk feet, early detection of neuropathy/ulceration, and referral into acute foot pathways as needed. Integrated within the multidisciplinary community diabetes team.	Reduces risk of serious foot complications; supports early intervention and prevents avoidable hospital admissions.

Sources: NCL ICB 2026; Royal Free London 2025; NCL Diabetes & Weight Management Network 2026; NCL NDPP 2026; Pouwels et al. 2023; NCL ICS 2024; Diabetes UK 2026

Community Workshops

Between November 2025 and January 2026, we carried out a series of community workshops, meeting with four local organisations (listed in Table 2). Across these sessions, 89 residents participated, sharing their experiences, current awareness, and perceptions of T2D.

Following the workshops, 61 participants provided feedback on how the sessions and the expert clinical advice offered shaped or changed their understanding of T2D, and how to prevent and manage the condition.

Methodology

We ran a series of workshops that combined focus group discussions with talks from NHS specialist speakers. Using focus groups helped us create open, in-depth conversations, allowing participants to share their experiences and opinions in their own words. This approach helped us understand the specific needs of local people, the barriers they face when accessing support, and their ideas for improving services.

To reach communities most at risk of T2D, we worked with grassroots organisations and VCSE groups in Enfield. These partners helped us arrange focus groups with seldom-heard communities. We contacted organisations by email, phone, and in-person at their events to encourage participation.

We also invited specialist speakers, including Diabetes Nurses and a Dietician from the NMUH Community Diabetes Team. Their involvement helped identify gaps in residents' knowledge and allowed participants to provide direct feedback that could be shared with NHS services.

All responses were anonymised and handled in line with GDPR and the Data Protection Act 2018.

Findings

The key themes presented in our findings emerged from our community workshops, and the focus group questions were developed with these themes in mind.

Together, they reflect participants' views, experiences, and understanding of T2D.

1 Knowledge & Awareness of Type 2 Diabetes

Participants shared what they knew about the causes, symptoms, and risks of T2D, including how personal or family experience influenced their awareness.

Health Behaviours & Managing Type 2 Diabetes 2

The steps individuals were taking to maintain their health, prevent T2D, or support someone living with the condition. It also captured how confident people felt in managing their health.

3 Barriers & Challenges to Healthy Living

Residents highlighted difficulties in sustaining healthy routines, including challenges related to diet, physical activity, motivation, and the wider environment.

Support in Managing Type 2 Diabetes 4

This included experiences of using local services and resources, how easy they were to access, what support was most helpful, and what additional services people felt were missing in the community.

Table 2 Workshop Participants and Demographic Profile

Organisations	No. of Participants	Age bracket	Ethnicity	Gender	Note
Centre for Social Inclusion	44	30 to 70+ years old	Asian British, Indian, South Asian, Black British, Black African, Black Caribbean, Mixed-Ethnicity	41 women, 3 men	Provides social welfare advice, immigration support, and daytime activities for older residents, along with ESOL and employment support classes.
One-to-One	11	20 to 60+ years olds	Bengali, Black British/African, White British	6 women, 5 men	One-to-One is a charity that supports Autistic people and people with Learning Disabilities.
One-to-One (consultation)	2	20 years olds	Black British, White British	2 women	One-to-One is a charity that supports Autistic people and people with Learning Disabilities.
Ordnance Road Methodist Church	8	30 to 70+ years olds	Black British, Black African, Black Caribbean, White British	7 women, 1 man	Hosts community coffee mornings offering a warm, welcoming space for residents to socialise and connect.
Sisters in Mind	24	20 to 70+ years old	South Asian, Black British, Black African, Black Caribbean, White European, White British, Mixed-Ethnicity	24 women	Sisters In Mind is a support network for women, offering solidarity and understanding through the challenges of modern life.

1. Knowledge & Awareness of Type 2 Diabetes

Most participants associated T2D with sugar, diet, and lack of exercise, describing what they know of the condition in terms of "sugar" and "bad food".

What they know...

Common T2D symptoms identified:

- fatigue
- excessive thirst
- frequent urination
- vision problems
- weight changes

Many recognised that diet and physical activity influence diabetes risk.

> We don't know what DESMOND is...

Knowledge Gaps

Participants were often unsure about:

- The difference between Type 1 and Type 2.
- What causes T2D and whether it can be prevented.
- Key tests like HbA1c and what they measure.
- The role of insulin and what pre-diabetes means.
- Risks vs complications (e.g. confusing symptoms with outcomes like blindness).

Healthcare Communication

Questions arose about stress, perimenopause, night shift work, mental health, medication side effects, and genetic risks — but many felt they lacked answers.

Most were unaware of support options such as myDESMOND, diabetes education programmes, and community diabetes teams.

> If I had known earlier, I would have cut down my consumption of junk food and sugar.

Experiences

One participant shared the serious impact of late diagnosis, including partial blindness and kidney disease.

One participant described receiving a diet sheet not aligned with their cultural foods, leading to confusion and disengagement.

Others experienced medication challenges, including worsening blood sugar before being switched.

Awareness of T2D was generally surface-level. Deeper understanding of causes, progression, and prevention was limited.

2. Health Behaviours & Managing Type 2 Diabetes

There was a mixture of proactive lifestyle changes that were discussed by participants as well as ways they manage their health.

Diet & Nutrition

- Reducing sugar, oil, salt, and portion sizes (e.g. smaller plates, fewer fizzy drinks).
- Adjusting meal times around shift work.
- Prioritising portion control rather than eliminating cultural foods.
- Eating more vegetables.
- Some tried intermittent fasting, with mixed success.
- Switching to healthier cooking methods (air fryers, oil sprays) and lower-sugar alternatives.

> **It's not the cultural food that's the problem — it's how much we eat.**

Physical Activity

Exercises and physical activities identified:

- walking daily, with dogs, or getting off the bus earlier
- swimming
- gardening
- Zumba and dance
- seated chair exercises
- house cleaning

Group activities like Zumba and walking groups helps to boost motivation.

Safety concerns and past trauma prevented some from walking outdoors.

Medication & Monitoring Health

Use of metformin, insulin, and glucose sensors (generally preferred to finger-prick tests).

Some switched medication due to side-effects.

Mixed awareness of how regularly GPs review test results and diagnosis.

A few relied on carers for help with routines, food prep, and reminders.

3. Barriers & Challenges to Healthy Living

There were various challenges participants faced which made it difficult to adopt and sustain healthy lifestyles.

GP Access & Clinical Support

Infrequent or unclear GP follow-up; many participants were unsure if results were being monitored.

Long waits to book a GP appointment to discuss results or diagnosis for T2D.

Some had their annual health checks (blood tets, foot checks, or eye screening). Others were unaware these checks were required annually.

Rushed appointments and inconsistent advice between clinicians.

Reliance on family for language and digital support raised confidentiality concerns.

Some participants turned to self-research (diet, medication, fasting) due to limited guidance.

Short-notice appointments; participants unsure why they had screening.

Lack of awareness of annual checks (foot, eye, HbA1c) and what "good control" entails.

Some participants felt unsure how to ask questions or who to ask.

> **They tell me to ask family – that's a breach of privacy, I don't want my children to know.**

Frustration with medication and "one-size-fits-all" instructions.

Language barriers made care harder to navigate or understand.

Confusion over whether patients should assume "no news is good news"

> **Salad does not fill me up.**

Participants of Black, Asian, and other ethnic minority groups felt dismissed, judged, or poorly supported by GPs.

Faith and community spaces provided emotional support, which were overlooked in clinical advice.

Dietary advice and portion sizes did not align with Caribbean, South Asian, and African cuisines.

Financial barriers

Healthy food (fresh produce) and gym memberships, were often said to be unaffordable.

Unhealthy food was seen as the only option for some households as it was cheaper.

Concern about the long-term financial burden of medication and chronic illnesses.

Digital Exclusion

> **I cannot open the link on my phone.**

Digital-only referrals and online diabetes education (e.g. DESMOND) excluded anyone without a smartphone or internet.

Participants reported not being offered non-digital diabetes education programme from their GP.

Low confidence using the NHS App to see results; many wanted digital training workshops.

Local gyms refusing cash payments.

Emotional Barriers & External Pressures

Irregular work hours, childcare, and low motivation disrupted healthy habits.

Mobility issues and lack of accessible transport prevented access to gyms, workshops, and appointments.

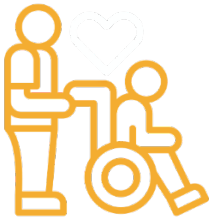
Caring responsibilities disrupted routines.

Participants expressed concerns on not knowing how to use glucose monitoring machines.

Navigating emotions, irritability, and anxiety associated with diabetes.

Trauma and safety concerns discouraged outdoor exercise and physical activity.

Mental health issues (anxiety, depression), stress, bereavement, and emotional eating affected meal choices, appointments, and exercise.



Issues such as lack of clinical support, cultural barriers, limited digital access, and high living costs make it challenging for residents to manage diabetes.

4. Support in Managing Type 2 Diabetes

Residents across all groups expressed a strong need for diabetes education that is accessible, culturally relevant, and available through non-digital formats to help them manage T2D with confidence.

Diabetes Knowledge and Guidance

Clear explanations of HbA1c, cholesterol, insulin, and pre-diabetes.

Guidance on portion sizes, meal timing, and affordable healthy cooking.

Early education offered in schools and communities to build lifelong awareness.

> **Knowing what to eat and when.**

Learning how to reduce risk when the whole family is at risk (e.g. pre-diabetes, genetics).

Support for carers to understand diet, risk, and management.

Dietitians trained in cultural diets and community-specific health risks.

Navigating emotions, irritability, and anxiety when living with diabetes.

Community-based Support

Community-led education to reduce misinformation and build confidence.

Group programmes for shared learning and motivation.

Sessions in local venues, drop-ins, flexible workshops (weekends/ evenings).

Accessible and Inclusive Healthcare

> **Digital Inclusion is a must!**

Regular reminders for annual checks (eye, foot, blood tests).

Clear GP follow-up pathways.

Digital Inclusion:

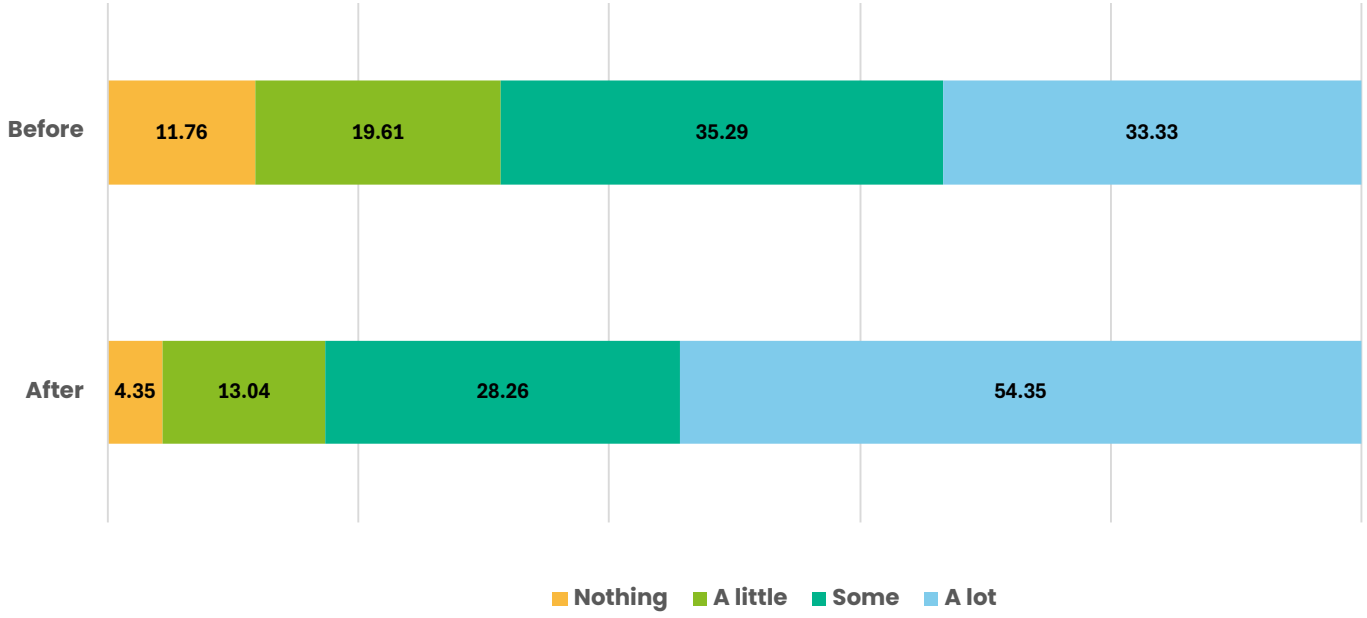
- Phone-based bookings
- Printed leaflets and visual meal guides
- face-to-face courses
- Digital literacy workshops (myDESMOND & NHS app)

5. Impact of the Type 2 Diabetes Workshops

Of the 89 participants who attended the T2D workshops, 61 provided feedback. They shared whether:

1. The workshops improved their understanding, awareness, and knowledge of the condition.
2. If it increased their confidence to manage or prevent T2D.
3. Offered suggestions for improvements and how the workshops made a difference to them.

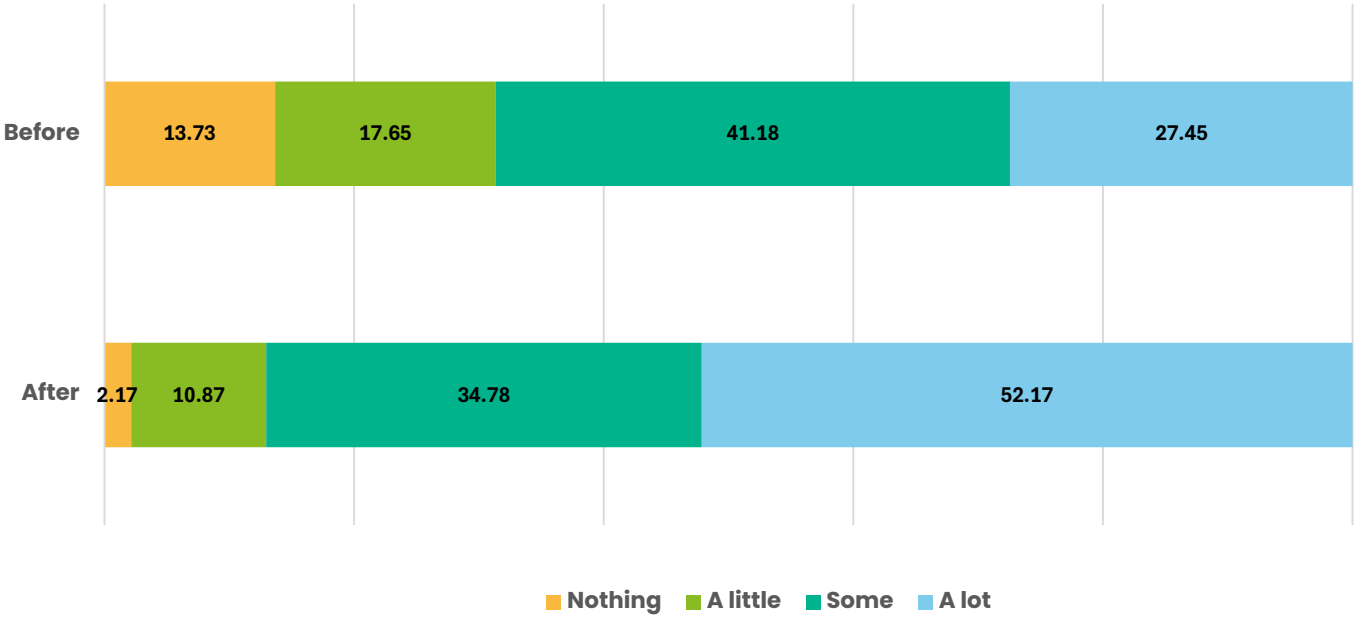
How much do you know about Type 2 Diabetes (T2D) causes and risk factors?



- Before the workshop only 33% knew "a lot" about T2D causes and 31% had little or no knowledge.
- After the workshop, “A lot” increased dramatically to 54%. Participants with no knowledge dropped from 12% to 4%.

More than half of participants left with a strong understanding of T2D causes and risk factors, a 21 point increase.

How much do you know about managing T2D (e.g. diet, exercise, medication)?



- After the workshop, "A lot" increased to 52% and "Nothing" dropped from 14% to 2%.

Participants showed a significant shift toward higher understanding, with the proportion of highly knowledgeable attendees almost doubling.

How confident do you feel in recognising T2D symptoms?

- Before the workshop, 24% felt “very confident” in recognising the symptoms and 39% felt not or slightly confident.

- After the workshop, “Very confident” increased to 26% (slight rise). Those not confident dropped from 27% to 11%, “Confident” rose from 37% to 48%.

The biggest improvement was the reduction of those not confident, a 16-point decrease.

How confident do you feel in managing or supporting someone with T2D?

- Before the workshop, nearly 54% were not or only slightly confident in managing and supporting someone with T2D. Only 21% felt “very confident”.

- After the workshop, “Very confident” increased to 30%. “Not confident” dropped from 31% to 11%. “Confident” increased from 25% to 36%.

Confidence improved across all levels, with a particularly strong decrease in participants feeling unprepared to support someone with T2D.

The workshops were highly effective. Participants showed:

- Higher knowledge levels across all areas (basic, self-management, symptom)
- Large increases in confidence, especially in recognising symptoms
- Major reduction in people with little or no understanding of T2D
- Improved readiness to support others

Participant written feedback showed strong satisfaction with the workshop, increased diabetes knowledge, and clear suggestions for improving future sessions.

Learning Outcomes

Most participants reported gaining practical, applicable knowledge, including:

- Food portions and healthier diet choices
- Managing Type 2 Diabetes and pre-diabetes
- Understanding blood tests (especially HbA1c)
- Awareness of risk factors
- Knowledge of community support and referrals (e.g. dieticians, DESMOND)

> Other risk factors I hadn't thought about.

> It was very useful education [&] is important.... would go to classes in my area.

> Can ask GP to be referred to the dietician...Need to do blood test every 6 months to monitor our HbA1c.

> Listening to everyone's point of view. This was very helpful.

Were questions answered?

93% ...said yes! Most felt their questions were addressed clearly and with patience.

A small minority still had unresolved questions, mainly relating to:

- Long-term management
- System-level issues
- GP accountability

> **They were absolutely brilliant and good to explain.**

Suggestions for Improvement

What they want more of:

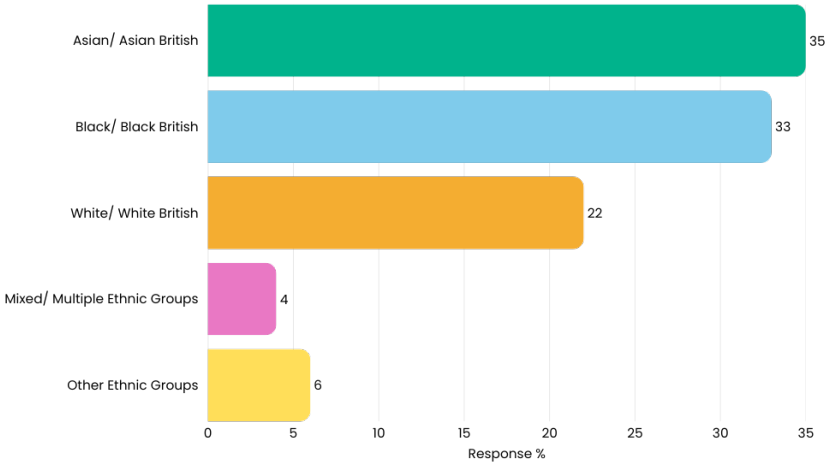
- More community sessions and wider access
- More detail on Type 1 vs Type 2
- Care tailored to the individual
- Regular sessions (every 6 months suggested)
- Leaflets and written materials in what type of food to eat and not to eat
- Better GP communication and clearer referral routes
- More time or a split-session format to avoid overload
- Sessions tailored for specific groups (e.g. men)
- Offer demonstrations on how to use and check blood sugar levels with Blood Glucose Monitors

> **There is a need for community-led initiatives that meet the needs of people on a local level.**

> **Maybe show how the blood is checked for people who have diabetes**

6. Demographics: Workshop Participants (n= 61 of 89)

Who took part...



35%

Asian/Asian British (Indian 13%, Asian British 11%, Bangladeshi 4%, and other Asian backgrounds 7%)

33%

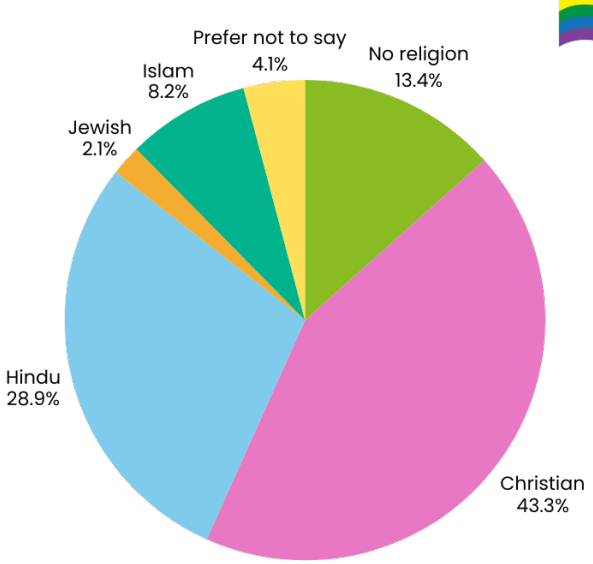
Black/Black British (Caribbean 17%, African 7%, and Black British 9%)

Strong engagement from older age groups (55+ years) who are at higher risk of Type 2 Diabetes.

76%

- Under 18 years 2%
- 25-29 years 4%
- 30-34 years 2%
- 45-49 years 10%
- 50-54 years 6%
- 55-59 years 10%
- 60-64 years 8%
- 65-69 years 16%
- 70+ years 42%

86% Women made up the large majority of respondents (86% female), with only a small proportion of men taking part.



5% Identified as bisexual, 73% hetreosexual, 20% prefer not to say.

36% Identified as Disabled.

13% Identified as carer or caring for someone.

Most attendees lived within Enfield and North London: EN1, EN2, EN3, N9, N18, N21.

Online Survey

An online survey ran from November 2025 to January 2026 to gather borough-wide views on T2D. Its purpose was to understand Enfield residents' awareness of the condition, their confidence in managing or reducing their risk, and their experiences of accessing support.

The survey also aimed to reach communities and demographic groups that are often underrepresented in face-to-face engagement activities. A total of 30 responses was collected.

Methodology

The survey contained a combination of closed-ended questions (multiple choice, rating scales, and demographic questions) and open-ended questions that allowed residents to describe their experiences in their own words.

Questions were structured around four core themes, as outlined on page 9 of the report.

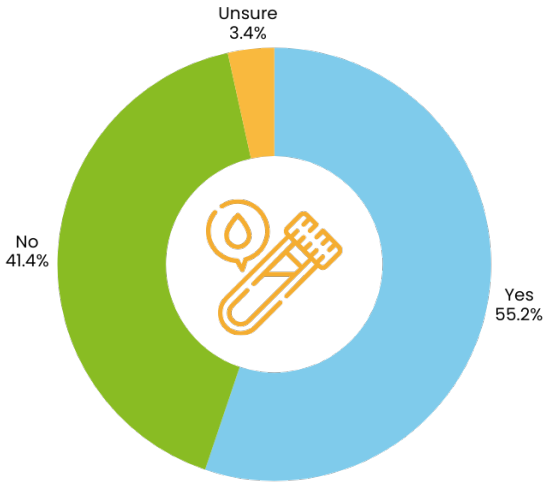
The survey link was distributed through local community networks, Healthwatch Enfield's digital channels, and partner organisations across the borough. All responses were anonymised in line with GDPR and the Data Protection Act 2018.

Findings

Our findings from the responses we collected in the online survey data.

1. Knowledge & Awareness of Type 2 Diabetes

Do you have Type 2 Diabetes?



31%

previously prediabetic or currently diagnosed with prediabetes

11%

said to be supporting/caring for someone with T2D

36%

said to have a family history of T2D, motly from their maternal line

Length of time living with T2D:

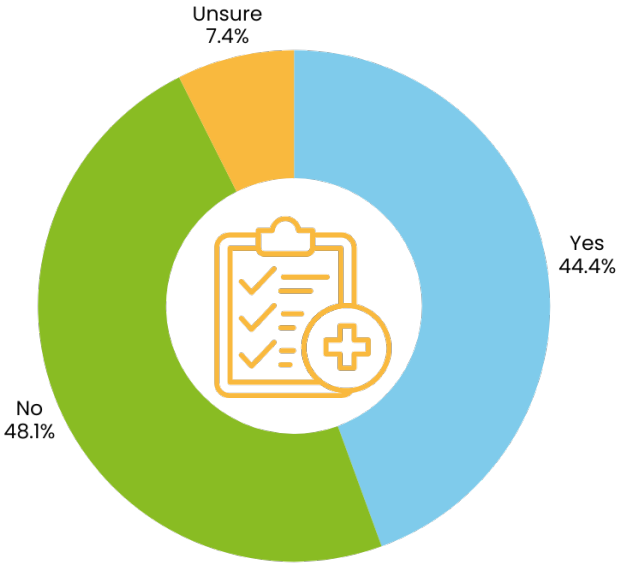
- Median: ~9.2 years
- Mean: ~12.6 years
- Range: 1.5 to 30 years

> **I get an annual review... but unsure whether this is a HbA1c test.**

44% confirmed to have checks, and Annual reviews, but there were issues:

- confusion about HbA1c blood tests
- delays causing anxiety

Have you had a diabetes health check in the last 12 months?



2. Health Behaviours & Managing Type 2 Diabetes

39%

do not feel confident in understanding T2D

18%

have been given enough information about T2D

28%

Know steps to reduce complications

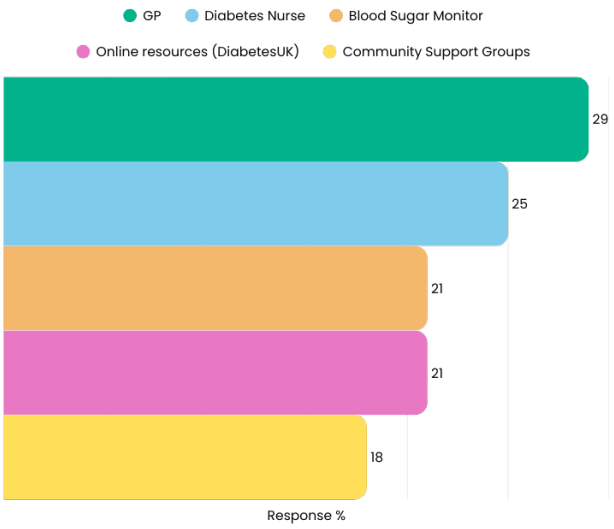
38%

Know steps to reduce risk of developing T2D

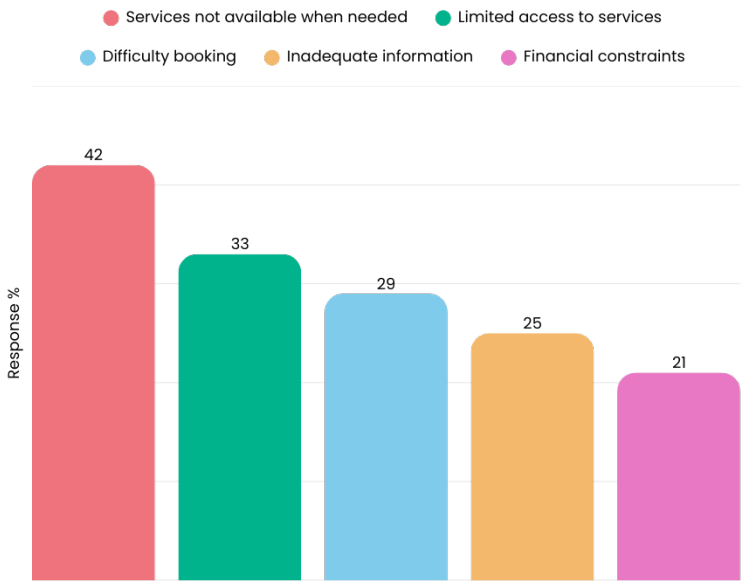
Services used to manage T2D

Residents told us:

- Support groups and pharmacists give clear, practical advice
- GP/clinic access is difficult, especially for housebound residents
- Diet advice can feel too rigid



3. Barriers & Challenges to Healthy Living



79%

say they have access to healthy and culturally appropriate food

46%

has easy access to places to carry out physical activity

Barriers to managing health

Residents told us:

- Healthy food is often too expensive, especially protein
- Local cafés/fast-food outlets offer few healthy or low-carb options
- Many struggle with motivation, cravings, pain, and weight management
- Some feel unsafe or worried about going out in public
- Mental health issues and Neurodivergence make it harder to manage day-to-day health

> **Need for ongoing support... doesn't mean it gets easier.**

4. Support in Managing Type 2 Diabetes

What would help? Residents say...

56%

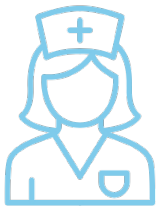
Regular health checks (HbA1c, podiatry)

52%

Personalised dietary advice

48%

Exercise and Physical activity guidance



44%

Individual 1:1 support

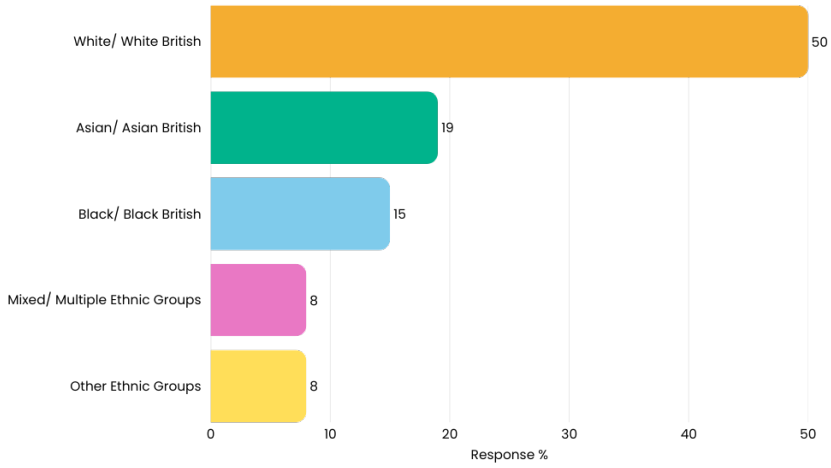
> **Cooking classes, more practical help. Plus shared knowledge on what others eat.**

Residents told us:

- They want long-term, not time-limited support
- Emotional wellbeing and motivation support to manage their health
- Neurodiversity inclusion for diabetes management
- They want practical skills (e.g. cooking classes, examples of real meals, how to exercise properly)
- Better access to GP care and clinical support

5. Demographics: Online Survey Participants (n=30)

Who took part...



50%

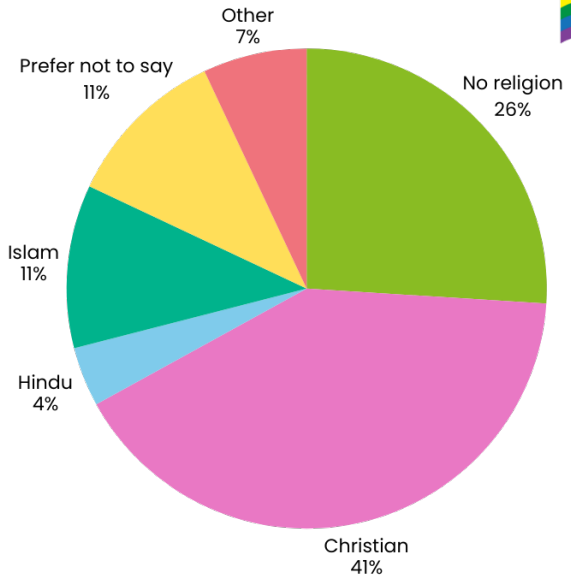
White/White British (White British 38%, and other White backgrounds 12%)

Strong engagement from older age groups (55+ years) who are at higher risk of Type 2 Diabetes.

67%

- 25-29 years 4%
- 30-34 years 7%
- 35-39 years 7%
- 40-44 years 4%
- 45-49 years 7%
- 50-54 years 4%
- 55-59 years 15%
- 60-64 years 11%
- 65-69 years 11%
- 70+ years 30%

86% Women made up the large majority of respondents (86% female), 14% of men taking part.



3% Identified as bisexual, 93% hetreosexual, 4% prefer not to say.

26% Identified as Disabled.

30% Identified as carer or caring for someone.

Responses span the borough, mainly from: N18, EN3, N13, N14, EN2, N21, EN1, N9.

Conclusion

A total of 119 participants across the workshops and online survey consistently expressed a strong need for diabetes education that is simpler, more accessible, and culturally relevant.

The dominant theme from the focus groups was a desire to understand why Type 2 Diabetes (T2D) guidance matters, rather than simply being told what to do. The online survey's dominant theme is that residents feel they are not receiving consistent, practical, and ongoing support to manage T2D and often end up navigating the condition largely on their own.

- Many participants had never accessed structured education and lacked reliable, easy-to-understand information presented in a format that suited their needs.

- Digital exclusion emerged as the most significant barrier, preventing many; particularly older adults, South Asian and Black communities, and those with limited digital skills from accessing programmes, booking GP appointments, or receiving follow-up support.

- Participants described emotional challenges such as loneliness, feeling overwhelmed, low motivation, and anxiety, all of which making managing their health harder.

- Practical lifestyle support was strongly requested, such as cooking classes, affordable healthy food, and real examples of what people can eat day-to-day

- Neurodivergence, long-term conditions, and chronic pain were identified as factors that can complicate the management of T2D.

- Residents were willing to engage with services but felt that current systems do not engage with them in return and were too short-term for a long-term condition.

Workshop engagement reflected Enfield's diversity, with 35% Asian and 33% Black participants. In contrast, the online survey saw a higher proportion of White respondents (50%). Both outreach activities had a majority of women participants, despite men being at a higher risk of diabetes (Diabetes UK 2024).

Inviting specialist speakers to the workshop and providing Diabetes UK resources had a positive impact across all learning and confidence measures. Participants demonstrated a 21% increase in overall knowledge, including basic understanding, symptom recognition, and self-management of T2D. Confidence levels also rose significantly, and readiness to support others improved, with those feeling not confident dropping from 31% to 11%.

Closing remarks

Overall, the findings highlight that education is the central need, for both residents (living with T2D or at risk) and the clinicians supporting them.

Enfield residents:

- want to understand the "why", not just be being told what to do
- need reliable, simple information in the right format
- want GPs to have more consistent knowledge about diabetes
- desire community empowerment in managing T2D

To build a more representative picture and ensure services meet the needs of all communities, future work should prioritise targeted outreach with:

- Men
- Younger adults (25–45 years old)
- South Asian, Black African, Turkish and Kurdish communities
- People living with Serious Mental Illnesses (SMI) and complex mental health needs

Recommendations

1. Improve Access to Information & Resources

- GP and Healthcare professionals to provide printed leaflets, booklets, and visual guides during diagnosis.
- Ensure non-digital alternatives (paper resources, printed results, phone lines) are always available alongside online platforms.
- Create simple, visual meal guides tailored to diverse cultural diets.
- Enfield Community Diabetes Team to provide take-home materials summarising key learning (e.g. portion guides, healthy food swaps, alcohol units) during outreach.
- Display diabetes information visibly in GP practices, community centres, pharmacies, and libraries.
- Promote Diabetes UK resources, which are free, practical, and culturally adaptable.

2. Strengthen Community-Based Education

- Expand local workshops (evenings, weekends, and drop-ins) to reach working adults and those unable to travel.
- Partner with community organisations, faith groups, and schools to deliver culturally relevant sessions.
- Offer family-focused diabetes education, especially where multiple household members are at risk. Can be held in schools, daycentres.

3. Enhance Clinical Communication

- GPs provide simple explanations of HbA1c, insulin, and pre-diabetes.
- Offer consistent follow-up pathways after diagnosis, including referrals to dietitians and diabetes education programmes.
- Deliver regular reminders for annual checks (eye, foot, blood tests).
- Improve access to the Community Diabetes Team, including drop-in opportunities and phone support.

- Provide reassurance and practical guidance to help people build confidence and reduce fear, especially around diagnosis or complications.
- Train clinicians in cultural and socio-economic competency, especially around food, risk, and communication styles.
- Offer the programme regularly (e.g. every 6 months) to reinforce learning.
- Consider shorter or modular sessions to reduce information overload.

4. Reduce Digital Exclusion

- Offer digital literacy workshops on the NHS App, myDESMOND, and GP online services.
- Ensure all referrals to DESMOND have non-digital alternatives.
- Provide phone-based bookings, printed course information, and face-to-face programme options.

References

1. **Diabetes UK** (2024) *Diabetes Is Serious: Inequalities and Early Onset*. Available at: https://www.diabetes.org.uk/support-us/campaign/diabetes-is-serious/across-the-UK/our-reports
2. **Diabetes UK** (2026) *Enfield Diabetes Support Group*. Available at: https://volunteer.diabetes.org.uk/teams/enfield/
3. **Diabetes UK** (2024) *Men at higher risk of type 2 diabetes due to pronounced insulin resistance of adipose tissue.* Available at: https://www.diabetes.co.uk/news/2024/may/men-at-higher-risk-of-type-2-diabetes-due-to-pronounced-insulin-resistance-of-adipose-tissue.html
4. **Enfield Council** (2024) *Joint Health & Wellbeing Strategy 2024–2030*. Available at: https://www.enfield.gov.uk/__data/assets/pdf_file/0027/48591/e46dfde9e57b0634bf030fb63166006b39a76534.pdf
5. **Gov.uk** (2025) *Diabetes Profile Statistical Commentary, March 2025*. Available at: https://www.gov.uk/government/statistics/diabetes-profile-update-march-2025/diabetes-profile-statistical-commentary-march-2025
6. **Healthwatch Enfield** (2025) *Investigating GP Support for Homeless People*. Available at: https://www.healthwatchenfield.co.uk/report/2025-12-11/investigating-gp-support-homeless-people
7. **NCL Health & Care** (2024) *NHS Diabetes Prevention Programme (NCL)*. Available at: https://nclhealthandcare.org.uk/keeping-well/nhs-diabetes-prevention-programme-dpp/
8. **NCL ICB** (2024) *Enfield Community Diabetes Service*. Available at: https://gps.northcentrallondon.icb.nhs.uk/services/community-diabetes-service-enfield
9. **NCL ICB** (2026) *Diabetes – NCL Diabetes & Weight Management Network*. Available at: https://gps.northcentrallondon.icb.nhs.uk/topics/diabetes
10. **NCL ICB** (2026) *Diabetes Prevention Programme (NDPP)*. Available at: https://gps.northcentrallondon.icb.nhs.uk/services/diabetes-prevention-programme-dpp
11. **NHS** (2026) *Type 2 Diabetes*. Available at: https://www.nhs.uk/conditions/type-2-diabetes/
12. **NHS England** (2024) *Digital Eye Screening Could Save Thousands of Appointments*. Available at: https://www.england.nhs.uk/2024/11/digital-eye-screening/
13. **North Central London Integrated Care System** (2024) *Diabetes Week 2024*. Available at: https://nclhealthandcare.org.uk/news/diabetes-week-2024/
14. **Nordström, A. et al.** (2016) *Higher Prevalence of Type 2 Diabetes in Men than in Women is Associated With Differences in Visceral Fat Mass*. Journal of Clinical Endocrinology & Metabolism, 101(10), pp.3740–3746. Available at: https://academic.oup.com/jcem/article/101/10/3740/2764924
15. **OHID** (2024) *Fingertips Diabetes Profile*. Available at: https://fingertips.phe.org.uk
16. **Pouwels, K.B. et al.** (2023) *'Referral to the NHS Diabetes Prevention Programme and conversion from non-diabetic hyperglycaemia to type 2 diabetes mellitus in England'*, PLOS Medicine, 20(2). Available at: https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004177
17. **Royal Free London NHS Foundation Trust** (2025) *Diabetes Service in the Community – Enfield*. Available at: https://www.royalfree.nhs.uk/services/community-services-enfield/diabetes-service-community
18. **Statista (2026)** *England: distribution of people with diabetes 2023/24, by gender*. Available at: https://www.statista.com/statistics/387302/individuals-with-diabetes-by-gender-in-england/

Statutory Population Data

- **OHID Fingertips Diabetes Profile** provides detailed local indicators including prevalence, treatment processes, screening uptake, and comparator benchmarks across England (OHID 2024).
- **Gov.uk Diabetes Profile (2025 Update)** offers up-to-date national data, such as GP-recorded prevalence (7.0% of adults in 2024) and trends in care processes, helping contextualise local findings (Gov.uk 2025).
- **Enfield JSNA, APHR, and Joint Health & Wellbeing Strategy (2024–2030)** provide high-quality local analysis on need, inequalities, obesity drivers, and system pressures, essential for local commissioning and policy alignment (Enfield Council 2024).
- **Statista** population datasets offer accessible demographic insights, including age structure, ethnicity distribution, and long term health trend estimates, helping to contextualise local diabetes risk factors and compare Enfield with wider regional patterns (Statista 2026).

NHS Documentation

- **NHS Type 2 Diabetes** provides a clear, authoritative definition of Type 2 diabetes, including symptoms, causes, and management, which is essential for public understanding and clinical reference (NHS 2026).
- **NCL/Enfield Community Diabetes Service** outlines local pathways, structured education (DESMOND/myDESMOND), neurovascular clinics, home visits, and dietetics; demonstrating the service infrastructure available to residents (NCL ICB 2024).
- **NHS Diabetes Prevention Programme (NDPP)** documents referral processes, eligibility criteria, and blended delivery (face-to-face and digital). This supports understanding of prevention pathways and uptake challenges (NHS England 2024).
- **Royal Free London NHS Foundation** Trust provides community diabetes support in Enfield, including podiatry, wellbeing coaching, multidisciplinary clinics, and virtual/face-to-face MyDESMOND education (Royal Free London 2025).

Voluntary and Charity Sector

- **Diabetes UK** provides patient-experience evidence, advocacy material, and policy briefings, including data on inequalities and young-onset T2D. These resources offer real-world insight into lived experience and systemic gaps (Diabetes UK 2024).
- **Healthwatch Enfield** produces community-centred research highlighting local health inequalities and barriers to accessing care. Their reports empower residents' voices and provide evidence to ensure local services address unmet needs and improve outcomes for diverse communities (Healthwatch Enfield 2025).

Glossary	Definition
Visceral fat	Fat stored deep inside the abdomen, surrounding internal organs. It is more biologically active than other fat and strongly linked to insulin resistance and higher Type 2 diabetes risk.
Adipose tissue	The body's fat-storing tissue. It stores energy and helps regulate hormones, but when it becomes insulin-resistant it increases the risk of developing Type 2 diabetes.

Healthwatch Enfield
Community House
311 Fore Street
London
N9 0PZ

www.healthwatchenfield.co.uk
t: 020 8373 6283
e: admin@healthwatchenfield.co.uk
@HealthwatchEnf
www.Facebook.com/healthwatchenfield