

**Module Title: Community Care and Management of Longer-term Conditions
(LCHS7003)**

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**Assignment Title: Component 1 Information Booklet of Long-term Condition
Management**

Audience: Patients and Service Users

Title: An Information Booklet on the Management of Type 2 Diabetes in the UK

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1. Introduction

Type 2 Diabetes (T2D) is one of the most significant and rapidly increasing long-term conditions in the United Kingdom. It is a metabolic condition that persists for a lifetime and if poorly controlled, causes serious problems with the heart, kidneys, eyes, nerves and feet. Unlike short-term illness, T2D requires constant management of the condition, lifelong professional support and lifestyle commitment. Yet with the right knowledge, treatment and care, living well with T2D is totally possible.



Figure: Diabetes type 2 patient in UK (Riddle et al., 2022)

The booklet has been addressed to you, people living at risk, or looking after someone with Type 2 Diabetes in the UK. It offers evidence based and understandable information on what T2D is, its impact on your physical, psychological and social life, your treatment options and the NHS, upon which your support depends and your national policies that influence your care. Data are provided in six tables bearing numbers, and are directly mentioned in the

text. It is hoped that you will be able to make informed decisions and effectively collaborate with your healthcare team with the knowledge to do so.

2. Definition, Prevalence and Risk Factors

What is Type 2 Diabetes?

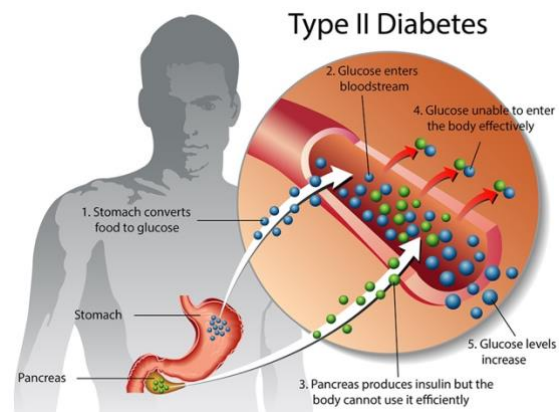


Figure: Type 2 Diabetes Mellitus (Holt and Flyvbjerg, 2024)

T2D is a chronic metabolic disease in which the body cannot generate enough insulin or use it efficiently - a phenomenon known as insulin resistance (Holt and Flyvbjerg, 2024). Insulin allows food glucose to get into cells to provide energy. When it fails, glucose will accumulate due to hyperglycaemia, which will gradually destroy blood vessels and nerves (Riddle et al., 2022). Notably, the Riddle et al. (2022) international consensus that remission (HbA1c below 48 mmol/mol maintained over three months in the absence of medication) is now a clinically recognised

attainable objective in some patients, fundamentally changed the perception of T2D. T2D is contrasted with Type 1 Diabetes where the pancreatic cells completely fail to secrete insulin usually necessitating insulin therapy throughout the life of a person since early years (Statista, 2026a).

Prevalence in the UK and Globally

T2D imposes a huge burden in the UK. In England, more than 3.5 million, and in Wales, 209,504 people were registered with T2D between 2023 and 2024 (Statista, 2026b). T2D prevalence in adults aged 17 and over recorded by GPs in England was 7.0% as of March 2024, compared to 6.8% the year before, and it is estimated that prevalence of both diagnosed and undiagnosed cases was 7.8% in 2021 (GOV.UK, 2025) - which proves that a significant proportion of people is still undiagnosed. In 2021, the UK was ranked third in Europe with about 141,000 diabetes-related deaths, and the prevalence rate of diabetes among adults at 9.2% (Statista, 2026a). In the UK, the anti-diabetes drugs market is estimated to have increased to 2026, at 7.25% annually to reach £1.88 billion (US\$2.40 billion), followed by an annual growth to 2030 (Statista, 2026c).

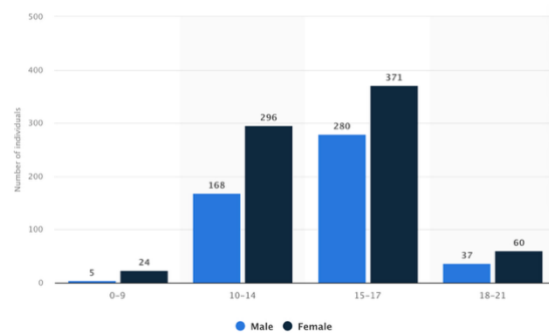


Figure: Children with type 2 diabetes in England and Wales 2022-2023, by gender and age (Statista, 2026c)

There are 537 million adults living with diabetes in the world today, which is expected to increase to 783 million in the year 2045 (Statista, 2026c). Of concern, in England and Wales, 1,241 children and the youth aged 24 years and below with T2D were recorded between 2022 and 2023, with the largest proportion aged 15–17 years (Statista, 2026d), indicating the increasing influence of obesity and inactivity on the young. Table 1 displays the age distribution of the T2D registration in England.

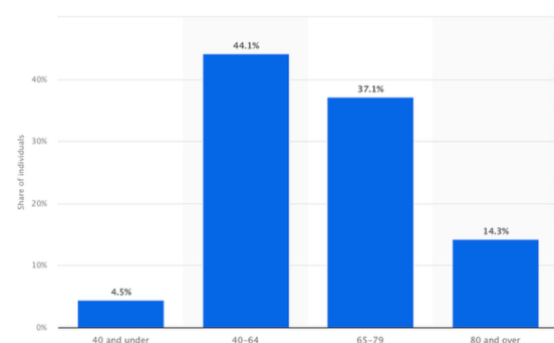


Figure: England: distribution of individuals with type 2 diabetes 2023/24, by age (Statsits, 2026e)

Table 1: Type 2 Diabetes Registrations in England by Age Group (2023/24)

Age Group	Proportion
40 years and under	4.5%
40–64 years	44.1%
65–79 years	37.1%
80 years and over	14.3%

Source: Statista, 2026e

As Table 1 indicates, T2D is a disease that is the most common in the age range of 40–64 (44.1%), yet its occurrence in every age category including children requires long-term preventive measures (Statista, 2026e).

Risk Factors

The most important step to prevent a risk is to understand it. Table 2 presents major risks factors.

Table 2: Risk Factors for Type 2 Diabetes

Non-Modifiable	Modifiable
Age over 40	Obesity and excess weight
Family history / genetics	Physical inactivity
South Asian, Black African/Caribbean ethnicity	High-sugar, processed diet
History of gestational diabetes	Smoking
Previous prediabetes	Excessive alcohol

Source: Caleyachetty et al., 2021; Rajput, Ashraff and Siddiqui, 2022

Rajput, Ashraff and Siddiqui (2022) affirmed in a narrative review conducted in the UK that the strongest modifiable risk factors to T2D are poor diet, excessive sugar intake and physical inactivity. A very critical and under-discussed risk dimension is ethnicity: Caleyachetty et al. (2021) in a large population-based cohort study found that South Asian people develop T2DM much earlier at lower BMI levels than whites in Europe, and thus, the conventional BMI cutoffs are systematically underestimating risk in these groups - a critical clinical gap that needs to be addressed urgently. Social economic deprivation adds to the risk and 23.6% of individuals with T2D in England reside in the most deprived quintile (Statista, 2026a).

3. Impact on Your Life and Available Treatments

Physical Impact

Uncontrolled sugar gradually destroys blood vessels and nerves. Microvascular complications can be retinopathy (blindness), nephropathy (kidney disease that leads to dialysis) and peripheral neuropathy with pain, tingling or numbness in feet and hands (Srikanth et al., 2020). Macrovascular complications have a great impact on raising cardiovascular disease, stroke and peripheral arterial disease. The

problem of diabetic foot disease, where neuropathy allows wounds to go unnoticed, potentially leading to amputation, is not the least important (Statista, 2026a). More importantly, Srikanth et al. (2020) established a strong two-way relationship between T2D and cognitive impairments, such as high dementia risk, which is rarely addressed but has far-reaching care effects. In 2018/19, the highest number of items was prescribed in comparison with 7.3 million in 2020/21 (Statista, 2026f), which is an alarming pattern since the clinical need only continues to increase.

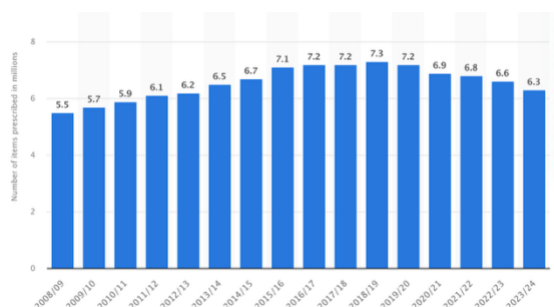


Figure: England: number of items prescribed for diabetes diagnostic agents 2008-2024
(Statista, 2026f)

Psychological Impact

Psychological burden of T2D is substantial, but it is never addressed appropriately. The frequent surveillance, nutrition control and drug compliance produce what scientists refer to as diabetes distress — emotional fatigue and disillusionment particular to the demands of living with the disease (Winkley et al., 2020). Systematic review study by Winkley and colleagues (2020)

established significantly high levels of depression and anxiety in T2D and showed that psychological interventions have a significant positive impact on mental health and self-management - but are still rarely integrated into standard diabetes management. In their systematic qualitative study, Powell et al. (2026) discovered that hypoglycaemia instilled widespread fear, limiting people in their daily lives and harming their social interactions. Their bold statement that there is more to life than HbA1c is a challenge to the clinical instinct of determining treatment success by entirely relying on biochemical indicators of the condition, rather than the entire lived experience.

Social Impact and Effect on Families

Using the data of UK Biobank, Sun et al. (2024) concluded that there was a significant correlation between worsening frailty and incident T2D, proving that the condition undermines independence and social engagement. In the UK, health spending per patient with diabetes was over £4,608 (US\$5,860) in 2021 (Statista, 2026a), and personal expenditure due to eating habits change, monitoring devices and unemployment further increased the financial burden. The effect is spread to families: Murphy et al. (2021) realised in a five-year nationwide cohort study that

women with T2D have significantly high risks of pregnancy complications, such as a higher risk of caesarean section and neonatal adverse outcomes. Informal carers often have huge unsupported emotional and practical pressures, indicating why whole-family solutions to diabetes support are urgently required.

NHS Evidence-Based Treatments

The NHS offers a wide pharmacological range of evidence-based treatment of T2D. Metformin is the most common first-line treatment, which is dispensed 26.4 million items in England in 2024 (Statista, 2026f).

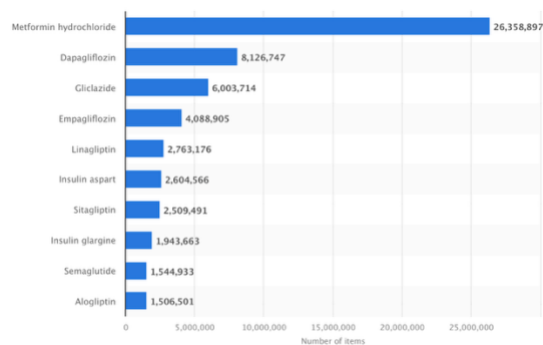


Figure: Leading drugs used for diabetes in England 2024, by items (Statista, 2026f)

The SGLT2 inhibitors and GLP-1 receptor agonists evidence base is constantly growing; however, the updated paper on pharmacological management of the topic by Senior et al. (2020) confirmed all of this. The phenomenon of oral semaglutide delivering clinically meaningful changes in HbA1c in routine practice was demonstrated by Marassi and Fadini (2025)

through real-life evidence. The ONWARDS 5 randomised trial (as demonstrated by Bajaj et al., 2023) demonstrated that an insulin dosing app of once-weekly icodec insulin reduced HbA1c levels as effectively as once-daily basal insulin, and also might lead to better adherence because of the decreased injection burden. Harrison et al. (2021) discussed an upcoming range of therapies, which included promising initial metabolic results of a phase 2 trial of berberine ursodeoxycholate in patients with T2D and non-alcoholic steatohepatitis. Elliott et al. (2021) showed that flash glucose monitoring was much more effective in HbA1c with T2D treated with basal insulin and broadens the access to technologies. The use of insulin increased continuously since 4.7 million items were prescribed in 2005/06, and 8.4 million insulin items in 2023/24 (Statista, 2026b), indicating increased complexity of treatment. The commonest prescribed diabetes drugs are summarised in Table 3.

Table 3: Most Commonly Prescribed Diabetes Medications in England (2024)

Medication	Items Dispensed	Drug Class
Metformin hydrochloride	26,358,897	Biguanide (first-line)
Dapagliflozin	8,126,747	SGLT2 inhibitor

Gliclazide	6,003,714	Sulfonylurea
Empagliflozin	4,088,905	SGLT2 inhibitor
Semaglutide	1,544,933	GLP-1 receptor agonist

Source: Statista, 2026f

In addition to medication there are structured education programmes DESMOND and X-PERT provided by the NHS. In a qualitative study, the authors discovered that meaningful engagement in self-management education had a significant effect on dietary knowledge, adherence and self-efficacy, but the presence of language barriers, gaps in cultural relevance and awareness, continued to hinder participation (Othman et al., 2022).

4. Models of Care

UK Model: NHS Expert Patient Programme

The NHS Expert Patient Programme (EPP) seeks to ensure that people with long-term conditions change from passive consumers of care into self-assured, empowered, self-managers. The EPP provides lay-led group education (encompassing symptom management, emotional coping and professional communication) and has shown a positive change in self-efficacy

and anxiety in T2D (Hawkes et al., 2024). Specifically, Hawkes et al. (2024) reviewed a national digital T2D self-management programme and reported high involvement and self-management confidence, which proves that the digital versions are effective in reaching the audience with barriers to face-to-face attendance.

There are, however, serious weaknesses to the EPP. Abu and Llahana (2025) demonstrated, in a systematic review, the same finding, that ethnic minority patients, who, in turn, have an unfairly high risk of T2D (Caleyachetty et al., 2021), cannot access the programme due to language barriers, cultural incompatibility, and a lack of awareness. This paradox implies that the EPP is likely to increase health disparities instead of reducing them and requires structural change, which is a fundamental requirement.

International Model: Wagner's Chronic Care Model

The Chronic Care Model (CCM) by Wagner is a system-level model that recognises six components: community resources, health system organisation, self-management support, delivery system design, decision support and clinical information systems (Holt and Flyvbjerg, 2024). The CCM acknowledges that effective diabetes management does not

need individual behaviour change only but organised health systems. In a randomised controlled trial (pharmacist-led carbohydrate restriction) in T2DM, Durrer et al. (2021) showed that structured multi-disciplinary care based on the principles of CCM yielded significant glycaemic control and body weight improvements.

A critical comparison of both models is in Table 4.

Table 4: Comparison of UK EPP and Wagner's Chronic Care Model

Feature	NHS Expert Patient Programme	Wagner's Chronic Care Model
Focus	Individual self-management	Systems-level + self-management
Delivery	Lay-led group education	Multi-disciplinary, planned care
Evidence base	UK-specific, EPP evaluations	Internationally validated
Key strength	Patient empowerment	Organisational integration
Key limitation	Excludes ethnic minority groups	US-context, needs NHS adaptation

Source: Holt and Flyvbjerg, 2024; Abu and Llahana, 2025; Hawkes et al., 2024; Durrer et al., 2021

Though special attention should be paid to adapting the CCM within the NHS setting,

its fundamental principles, such as proactive planned care, centrality of self-management and integration of clinical data, have a well-established presence in the present day NHS strategy of diabetes and offer a good international reference point.

5. Policy and Political Agendas

NHS Long-Term Plan and National Diabetes Prevention Programme

The NHS Long-Term Plan (2019) took the pledge to scale up the National Diabetes Prevention Programme (NDPP), enhancing the rate of uptake of structured education and expanding access to glucose monitoring. The NDPP submits the high-risk people to evidence-based lifestyle programmes to delay or prevent the onset of T2D. Organised attendance at education among patients diagnosed with T2D in the early phases of the disease rose by 27% in 2021-2022, although it is still much lower than it was in 2019 before the pandemic (GOV.UK, 2025) - revealing the disruptive heritage of COVID-19 in diabetes care. There is also still a problem of regional inequalities: the highest estimated prevalence of T2D was found in the West Midlands (8.6%) and lowest in the South East (7.0%), which requires locally-specific policy measures (GOV.UK, 2025).

NICE Guidelines NG28 and Care Process Delivery

NICE Guideline NG28 offers the increasingly definitive UK clinical guideline on T2D including drug pathways, blood sugar goals and formatted education criteria. Although new patients diagnosed with the disease must take structured education during the first year of the diagnosis, there are still considerable gaps in implementation. Table 5 demonstrates the achievement rates of care processes.

Table 5: NHS Diabetes Care Process Achievement Rates, England (2023/24)

Care Process	T1D	T2D
HbA1c monitoring	84.1%	95.7%
Blood pressure check	88.0%	94.2%
Cholesterol check	78.8%	90.8%
Retinal screening	57.8%	71.0%
Foot surveillance	70.6%	81.3%
All 9 care processes	42.2%	54.3%

Source: Statista, 2026a; GOV.UK, 2025

As Table 5 demonstrates, only 54.3% of people with T2D received all nine recommended care processes in 2023/24 — an improvement from 48.9% previously, but still meaning nearly half receive incomplete care (GOV.UK, 2025; Statista, 2026c). Retinal screening completion at 71.0% is particularly concerning given the direct link to preventable blindness. The net

ingredient cost of diabetes drugs in England reached £1.53 billion in 2022/23 (Statista, 2026f) — a vast investment undermined when preventive care processes reducing costly complications remain incomplete. In Wales, the Diabetes Delivery Plan and A Healthier Wales strategy set parallel ambitions, yet care process completion mirrors England's shortfalls (Statista, 2026b), confirming that coordinated cross national solutions are required.

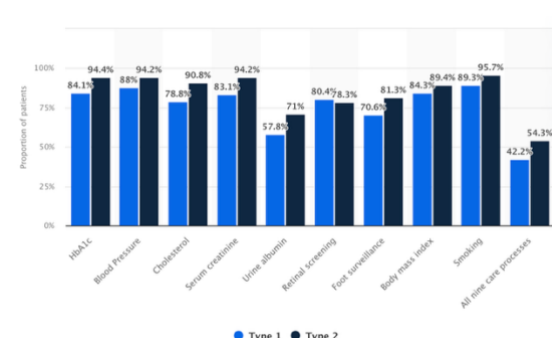


Figure: England: share of patients receiving care processes for diabetes 2023/24, by type (Statista, 2026c)

6. Recommendations

Table 6 summarises evidence-based recommendations across six priority areas.

Table 6: Recommendations for Improved T2D Management in the UK

Priority Area	Recommendation
Person-centred care	Shared decision-making beyond HbA1c targets
Self-management education	Culturally and linguistically adapted DESMOND/X-PERT

Digital health	NHS-approved apps, flash monitoring, weekly insulin
Psychological support	Routine distress and anxiety screening at annual reviews
Health inequalities	Targeted outreach for ethnic minority and deprived communities
End-of-life care	Relaxed targets; deprescribing; comfort and dignity focus

Source: Author's synthesis of reviewed literature

All T2D management should be based on person-centred care. Powell et al. (2026) eloquently illustrate that HbA1c does not effectively outline the complete human experience of having T2D. Collaborative decision-making - in which the clinician and the patient jointly discuss available options and objectives - has always been shown to enhance satisfaction, adherence and outcomes.

Self-management education should be made really accessible. As Abu and Llahana (2025) exhibit, the existing programmes are currently biased against the most vulnerable. Language-appropriate adaptations of DESMOND and X-PERT should be culturally adapted to communities. Gortzi et al. (2024) identified the significance of community-level tailored intervention, as the results of their study proved that structured, targeted

nutrition education effectively promoted dietary behaviour and glycaemic control in T2DM.

Online health applications have a far-reaching self-management. As Hawkes et al. (2024) showed, digital programmes enhanced engagement and self-efficacy in the participants with the barriers to face-to-face attendance. When equitably accessible, the flash monitoring (Elliott et al., 2021) and weekly insulin technologies can also decrease the treatment burden.

Psychological assistance should be incorporated in regular care of diabetes. Winkley et al. (2020) prove that psychological interventions do not only enhance self-management and mental wellbeing in T2D, but they are also not consistently offered by NHS services. Annual distress, depression and fear of hypoglycaemia screening followed by clear referral pathways should become a normal practise.

To solve health inequalities, it is necessary to take proactive measures. The high ethnic minority risk exhibited by Caleyachetty et al. (2021), the barriers of access as found by Abu and Llahana (2025), and the concentration of T2D by poverty, coupled with the ethnic minorities (Statista, 2026a) together require actively reaching underserved communities by healthcare

systems via trusted organisations and multilingual materials.

Palliative care is greatly disregarded. Clinical attention to people with severe T2D complications and near end of life should change towards comfort, dignity and quality of life rather than intensive glucose control, which would lead to detrimental hypoglycaemia. It is not only clinical but also humane to deprescribe unneeded drugs and make patients and families part of an advance care plan (Holt and Flyvbjerg, 2024).

7. Conclusion

Type 2 Diabetes is a complex life-long disorder that affects millions of people in the UK, and more than 3.5 million people are registered in England alone and prevalence is on the rise in all age groups including children. It has a variety of consequences on physical complications, psychological distress, social disruption, family burden, as well as substantial economic cost that make it one of the most urgent health issues that the UK is currently experiencing.

The NHS offers significant interventions ranging from metformin to newer medications such as SGLT2 inhibitors and GLP-1 agonists, emerging medications, weekly insulin and monitoring systems.

Nevertheless, as only 54.3 percent of T2D patients undergo all nine care processes, self-management education does not benefit those at the highest risk, ethnic-specific risk is systematically underreported, diet and lifestyle interventions are not sufficiently exploited.

T2D management requires a person-centred and holistic approach to the treatment, putting your personal experience, goals and wellbeing at the heart of the treatment. The NHS Expert Patient Programme and Chronic Care Model by Wagner are excellent yet flawed frameworks that need radical adjustments to address the needs of all individuals with T2D in the UK. You are not the only one who has to cope with this condition - and with the appropriate help, the outstanding results are available.

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