

Community Management of Type 2 Diabetes in the United Kingdom:

A Critical Evaluation of Impact, Policy, and Integrated Care Models

Programme: **MSc Public Health and Social Care in Practice**

Module Title: **Community Care and Management of Long-Term
Conditions (LCHS7003)**

Student Name: **Mst Rahima Arobe Akhi**

Student Number: **2524399**

Lecturer: **Muhammed Khan**

Submission Date: **19 March 2026**

Word Count: **3166**

TABLE OF CONTENTS

Introduction.....	3
Understanding Diabetes Mellitus	4
Definition	4
Type 1 Diabetes mellitus (T1DM)	4
Type 2 Diabetes mellitus (T2DM)	4
Epidemiology and Burden of Disease	5
Worldwide Prevalence	5
UK Prevalence	5
Aetiology and Risk Factors	6
Physical Impact of Diabetes	7
Microvascular Complications	8
Macrovascular Complications	8
Psychological Impact of Diabetes.....	8
Social impact and family implications.....	9
Evidence-Based Management in the UK.....	9
Lifestyle Modification.....	9
Pharmacological Therapy	10
Education and Self-Management Support	10
Integrated and Personalised Care	10
Theoretical Models for Long-Term Condition Management.....	11
Political and Policy Context	12
Recommendations for Improved Care.....	13
Self-Management and end-of-life care in diabetes	14
Conclusion.....	14
Reference.....	16

INTRODUCTION

Diabetes Mellitus is a long-term metabolic condition in which the body cannot properly regulate **blood glucose** levels (American Diabetes Association, 2023; WHO, 2023). This happens when the **pancreas** makes **inadequate insulin** or when insulin is not **used efficiently** by the body (Davies et al., 2022). The World Health Organization identifies diabetes as a **major cause of preventable morbidity and mortality** worldwide.

More than **5 million** individuals in the **United Kingdom** have **diabetes**, and the prevalence **continues to grow** (Diabetes UK, 2023). Roughly **90%** of diabetes cases are **Type 2 Diabetes Mellitus (T2DM)**, whereas about **8%** are **Type 1 Diabetes Mellitus (T1DM)**. In addition, more than one million individuals are estimated to remain undiagnosed (NHS England, 2023). However, the burden of diabetes is not distributed equally. Greater prevalence is seen in socioeconomically deprived areas and among some **ethnic minority groups**, emphasizing the importance of broader social and structural influences on health (Office for Health Improvement and Disparities, 2023).

Type 1 Diabetes is an **autoimmune disorder** that depends on **lifelong insulin treatment**, whereas Type 2 Diabetes has a strong

connection with **modifiable determinants** and may often be **prevented or even reversed** with early intervention (Davies et al., 2022). Despite national prevention strategies and policy commitments, prevalence continues to increase, raising questions about the effectiveness and sustainability of current approaches (NHS England, 2023).

Community-based management is therefore central to improving outcomes. Effective diabetes care extends beyond medication and requires **coordinated primary care, structured education, digital innovation, and culturally responsive support** (Powers et al., 2020).

This booklet **critically evaluates the community management of Diabetes Mellitus** in the UK, with a primary emphasis on Type 2 Diabetes, as it represents **most cases** and can **largely be prevented**. Comparative insights into Type 1 Diabetes are incorporated to demonstrate differences in pathophysiology, lived experience, and service provision. Through analysis of **evidence-based guidelines, theoretical care models, and policy frameworks**, this booklet examines both achievements and **ongoing challenges** in delivering equitable and sustainable diabetes care.

UNDERSTANDING DIABETES MELLITUS

DEFINITION

Diabetes Mellitus is a **long-standing metabolic disorder** that affects how the body manages **blood glucose**, which is the key energy supply for cells. Under normal conditions, **insulin** enables the transfer of glucose from the blood into body tissues where it is used as energy. In diabetes, however, insulin production is reduced or its effectiveness is impaired, resulting in consistently elevated **blood sugar levels** (Davies et al., 2022).

Diabetes has two main forms: **Type 1 Diabetes Mellitus (T1DM)** and **Type 2 Diabetes Mellitus (T2DM)**. While both conditions cause elevated blood glucose levels, they vary greatly in terms of causes, development, and treatment (International Diabetes Federation, 2023).

TYPE 1 DIABETES MELLITUS (T1DM)

Type 1 Diabetes is an **autoimmune disorder** in which the immune system targets and damages the **beta cells** in the pancreas that

produce insulin, resulting in **insulin deficiency**. It often begins in childhood and requires **lifelong insulin therapy** (Holt et al., 2021). Despite advances in technology, T1DM remains associated with risks such as **hypoglycaemia** and **long-term complications** (American Diabetes Association, 2023).

TYPE 2 DIABETES MELLITUS (T2DM)

Type 2 Diabetes occurs when the body becomes **resistant to insulin**, and the insulin-producing cells gradually lose their function. Type 2 Diabetes Mellitus is connected to determinants such as **obesity, ageing, genetic predisposition, sedentary lifestyle, and socioeconomic deprivation** (Davies et al., 2022). Its prevalence is rising, particularly in **deprived communities** and certain **ethnic minority groups**, reflecting the influence of **socioeconomic and environmental** influences on health (Office for Health Improvement and Disparities, 2023). Unlike T1DM, T2DM is largely **preventable** and, in some cases, **reversible** through substantial weight loss and **lifestyle intervention**.

EPIDEMIOLOGY AND BURDEN OF DISEASE

WORLDWIDE PREVALENCE

Globally, diabetes is a rapidly increasing **public health concern**, with prevalence rising across all regions worldwide.

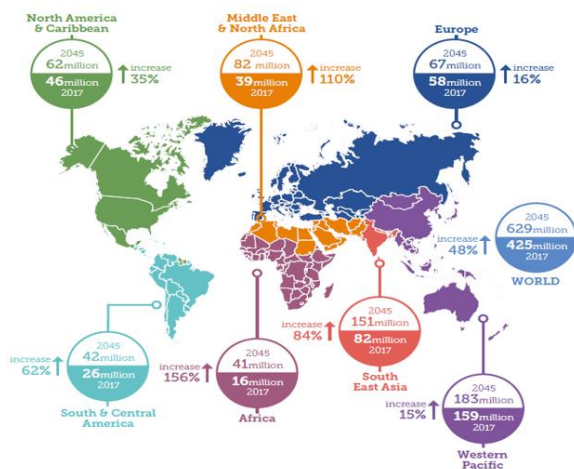


Figure: Global distribution of diabetes prevalence and projections (Source: International Diabetes Federation)

This figure highlights **geographical variations** in diabetes prevalence. For example, the **Western Pacific region** had approximately **206 million cases** in 2021, with figures expected to reach roughly **260 million by 2045**, while **South-East Asia** reported about **90 million cases** with substantial future increases. The **Middle Eastern and North African region** shows one of the **fastest growth rates**, with cases expected to

increase by over **100%**. Overall, the global prevalence of diabetes was estimated at **537 million adults in 2021**, with numbers expected to rise to **783 million by 2045**, demonstrating a significant worldwide increase (International Diabetes Federation, 2021; Sun et al., 2022).

UK PREVALENCE

In the **United Kingdom**, diabetes continues to affect a growing proportion of the population, with both **diagnosed and undiagnosed cases** contributing to the overall burden.



Almost 3.7 million
people have been diagnosed
with diabetes in the UK



12.3 million
people are at **increased risk**
of Type 2 diabetes



4.6 million
people are living with
diabetes in the UK

Figure: Estimated UK Diabetes Burden (Source: Kidney Research UK)

This figure shows that approximately **3.7 million people** in the United Kingdom have been identified as having diabetes, while total cases are estimated at **4.6 million** when including undiagnosed individuals. It also indicates that approximately **12.3 million adults** are more likely to develop Type 2 diabetes, emphasising the scale of the current and future burden (Diabetes UK, 2023).

The **12.3 million individuals** identified as **high risk** further demonstrate the urgent need for **effective prevention strategies**. Without structured lifestyle interventions, targeted screening, and community-level support, many of these individuals may progress to Type 2 diabetes (NHS England, 2023).

Diabetes also carries a substantial **economic burden**, with healthcare costs continuing to increase due to **complications** and **long-term treatment needs** (Bommer et al., 2021). Approximately **10% of the NHS budget** is allocated to diabetes care and its associated complications (Diabetes UK, 2023). Importantly, prevalence is higher in **socioeconomically deprived communities** and among **South Asian** and **Black ethnic groups**, reflecting the influence of structural **health inequalities**.

Despite increased awareness and **national prevention programmes**, the rising prevalence of diabetes suggests that current public health strategies may not be sufficiently effective.

AETIOLOGY AND RISK FACTORS

A clear understanding of the underlying causes and determinants of diabetes is vital for management and preventive measures, as Type 1 and Type 2 diabetes develop through distinct **pathological mechanisms**.

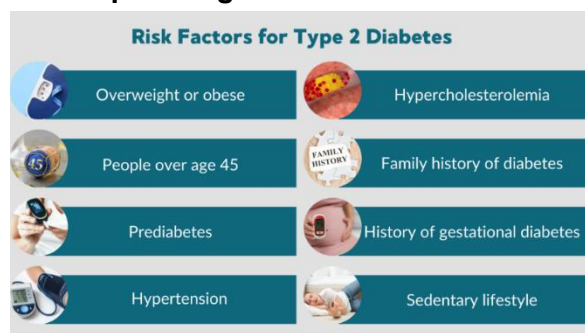


Figure: Risk Factors for Type 2 Diabetes
(Source: ITS Nutriscience)

The figure highlights key risk factors linked to Type 2 diabetes, such as **overweight or obesity**, **high cholesterol**, **age over 45**, **family history**, **prediabetes**, **previous gestational diabetes**, **hypertension**, and **sedentary lifestyle** (International Diabetes Federation, 2023).

Type 1 diabetes is an autoimmune disorder in which the immune system destroys the pancreas's **insulin-producing beta cells**, causing a **complete deficiency of insulin**. It is **not preventable** and is influenced by **genetic**

predisposition. **Lifelong insulin therapy** is therefore required to maintain **glycaemic control** (American Diabetes Association, 2024).

On the other hand, Type 2 diabetes mainly develops due to **impaired insulin sensitivity**, where body tissues respond poorly to insulin. Gradually, **pancreatic beta-cell function declines**, resulting in persistent **hyperglycaemia**. Central obesity significantly increases insulin resistance and systemic inflammation (NICE, 2022).

Although **family history** increases risk due to **inherited genetic factors**, **ethnicity** and

social context also play critical roles. Those from **South Asian** and **Black African-Caribbean backgrounds** have a higher likelihood of developing Type 2 diabetes and often present earlier than White populations (Diabetes UK, 2023).

Socioeconomic deprivation further increases risk, with restricted access to **nutritious food**, **opportunities for physical activity**, and **healthcare** contributing to a higher prevalence in **deprived communities** (Office for Health Improvement and Disparities, 2023).

PHYSICAL IMPACT OF DIABETES

Diabetes has widespread effects on the body, particularly when blood glucose levels remain poorly controlled over time. **Chronic hyperglycaemia** damages **blood vessels**, **nerves**, and **tissues**, leading to progressive **complications** that **reduce quality of life** and increase **healthcare use** (WHO, 2023). These complications develop gradually and often remain undetected until significant damage has occurred.

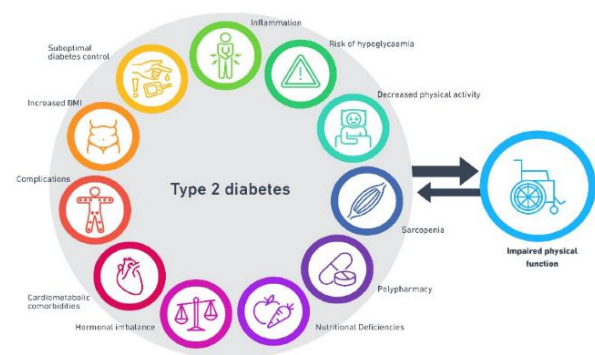


Figure: Type 2 Diabetes and Impaired Physical Function: A Growing Problem
(Source: MDPI)

The figure illustrates the relationship between Type 2 diabetes and **declining physical function**, including factors such as **systemic inflammation**, **hypoglycaemia risk**, **reduced**

physical activity, sarcopenia, hormonal imbalance, cardiometabolic conditions, and increased **complication risk**. Persistent **hyperglycaemia** is the primary driver of **tissue damage** (NICE, 2022). Complications are commonly categorised as **microvascular** or **macrovascular**.

MICROVASCULAR COMPLICATIONS

Affecting **small blood vessels**, comprise:

- **Diabetic retinopathy**, a significant contributor to **avoidable vision loss** (Diabetes UK, 2023).
- **Diabetic nephropathy**, which can result in **impaired kidney function** or **failure** (NICE, 2022).
- **Peripheral neuropathy**, increasing risk of **foot ulcers** and **amputation** (WHO, 2023).

MACROVASCULAR COMPLICATIONS

Affecting **large blood vessels**, including:

- **Ischaemic (Coronary) heart disease**
- **Cerebrovascular disease (stroke)**
- **Disorder of the peripheral circulatory system**

Diabetes increases the likelihood of **cardiovascular disease** by **two to three times**, which accounts for most **diabetes-related deaths**.

Diabetes also contributes to reduced **muscle mass** and **strength**. **Insulin resistance**, **chronic inflammation**, and **metabolic dysfunction** accelerate **sarcopenia**, particularly in **older adults** (Sinclair et al., 2020).

PSYCHOLOGICAL IMPACT OF DIABETES

Experiencing Diabetes Mellitus can significantly affect **psychological well-being**. Daily **self-management**, including **glucose monitoring**, **diet**, **medication**, and **lifestyle adjustments**, can lead to **emotional strain**, **anxiety**, and reduced **quality of life**. Fear of complications such as **blindness**, **kidney failure**, or **amputation** may further increase **stress** (WHO, 2023; Diabetes UK, 2023).

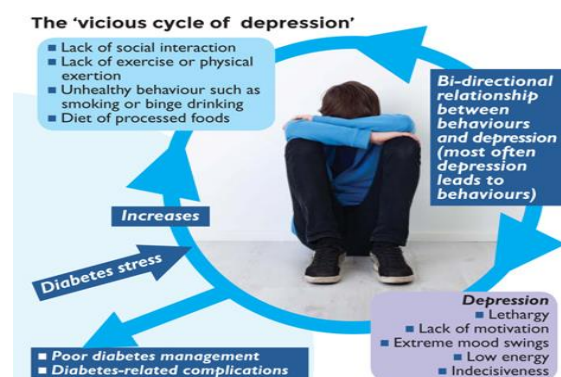


Figure: The psychological impact of diabetes – Diabetes Research & Wellness Foundation

Research distinguishes between **clinical depression** and **diabetes distress**, the latter referring to the **emotional burden** of managing the condition (NHS England, 2023). If unrecognised, this can lead to **poor glycaemic control** and increased **complications**. **Depression** is nearly **twice as common** in people with diabetes, while **diabetes distress** affects up to **one-third of individuals** (Fisher et al., 2021).

These findings emphasize the need to incorporate **mental health support** into routine diabetes care, including regular **psychological assessment** and access to appropriate **interventions** (NICE, 2022).

SOCIAL IMPACT AND FAMILY IMPLICATIONS

Diabetes affects not only individuals but also **families** and **communities**. Impacts include:

- **Reduced employment productivity**
- **Financial strain**
- **Caregiver burden**
- **Social isolation**

Families often take on **informal caregiving roles**, notably for **older adults** with **Type 2 diabetes** and **younger individuals** with **Type 1 diabetes**, which can result in **emotional** and **economic stress** (Diabetes UK, 2023).

Health inequalities further worsen these outcomes, as individuals in **deprived areas** face increased **complication rates** and limited access to **education** and **support services** (UK Health Security Agency, 2022; Marmot, 2020). In many cases, family members may experience **emotional stress**, **financial pressure**, and changes in **daily responsibilities**, which can affect their own **health** and **well-being** over time.

EVIDENCE-BASED MANAGEMENT IN THE UK

Type 2 Diabetes management in the UK is directed by **NICE (2022)**, with the aim of improving **glycaemic control**, reducing **complications**, and enhancing **overall well-being**. Care is **multifactorial**, combining **lifestyle intervention**, **medication**, **education**, and **monitoring** (NHS England, 2023).

LIFESTYLE MODIFICATION

Lifestyle intervention is the **foundation of management**. NICE emphasises **weight reduction**, **healthy eating**, and **regular physical activity** (NICE, 2022).

- **Weight management:** Reducing **body weight** enhances **insulin sensitivity**, and **remission** is possible in some cases (McCombie et al., 2021).
- **Physical activity:** A minimum of **150 minutes per week** improves **metabolic health** (WHO, 2023).

The **NHS Diabetes Prevention Programme** supports **high-risk individuals** and reduces progression to **Type 2 diabetes**, although **uptake varies** (Kar et al., 2022). However, the effectiveness of lifestyle interventions is often limited by **poor adherence**, **social inequalities**, and a lack of **long-term support**. Individuals in **deprived areas** may experience challenges, including limited availability of **healthy food** and **safe places to exercise**, reducing the success of these interventions.

PHARMACOLOGICAL THERAPY

When **lifestyle measures** are insufficient to achieve **individualised HbA1c targets**, **pharmacological treatment** is introduced (NICE, 2022).

- **Metformin** remains **first-line** due to **safety** and **cost-effectiveness**.
- **SGLT2 inhibitors** are recommended for **heart** and **kidney benefits**.
- **GLP-1 analogues** support **glycaemic control** and **weight loss**.

- **Insulin therapy** is used when other treatments are **inadequate** (European Society of Cardiology, 2021).

While pharmacological treatments are effective in controlling **blood glucose**, they do not address the underlying **social** and **behavioural causes** of **Type 2 Diabetes**. In addition, some **newer medications** may not be equally accessible to all patients due to **cost** and **prescribing variations**.

EDUCATION AND SELF-MANAGEMENT SUPPORT

Structured education is a **core component** of UK diabetes care. Programmes like:

- **DESMOND (for Type 2 Diabetes)**
- **DAFNE (for Type 1 Diabetes)**

support **knowledge development**, **behavioural change**, and **confidence in self-management**. Participation in structured education is associated with improved **glycaemic outcomes** and **self-efficacy** (NICE, 2022).

INTEGRATED AND PERSONALISED CARE

Diabetes management in the UK is delivered primarily through **multidisciplinary primary care teams**, including **GPs**, **diabetes specialist nurses**, **dietitians**, and

pharmacists (Diabetes UK, 2023). Regular monitoring — including **HbA1c**, **lipid profile**, **renal function**, and **retinal screening** — enables early identification of **complications** (NICE, 2022).

At the local level, diabetes care is delivered through **GP practices**, **community diabetes teams**, and **Integrated Care Systems (ICS)**. These services aim to provide **coordinated** and **accessible care** closer to home. However, the **quality** and **availability** of services can vary significantly between regions, leading to inequalities in access to **care** and **health outcomes**.

Despite these benefits, the delivery of **integrated care** is often inconsistent across regions due to **workforce shortages**, **time constraints**, and variation in **service availability**. This can result in unequal **patient experiences** and **outcomes**.

THEORETICAL MODELS FOR LONG-TERM CONDITION MANAGEMENT

Effective diabetes management requires **structured care models** that support **self-management** and **coordinated care** (WHO, 2023).



Figure: House of Care model (Source: NHS England)

The **House of Care model** emphasises **collaborative care planning**, **personalised goals**, and integration of **community support**. It promotes **patient involvement** to improve **adherence** and outcomes, but depends on **workforce capacity** and **infrastructure** (NHS England, 2021).

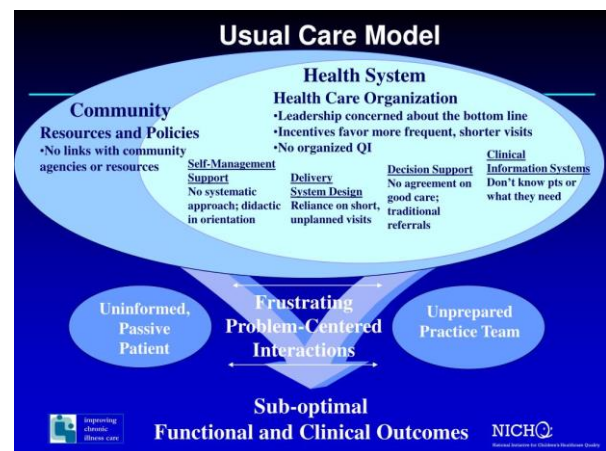


Figure: Chronic Care Model (Source: SlideServe)

Internationally, the **Chronic Care Model (CCM)** serves as a key approach to **chronic**

disease management. It identifies six interrelated elements:

- **Support for self-management**
- **Decision-making support**
- **Clinical information systems**
- **Care delivery system design**
- **Community-based resources**
- **Organisation of the health system**

Both models promote **proactive, person-centred care** and **early intervention**. However, challenges such as **workforce shortages, funding variation, and digital exclusion** limit implementation.

Although these models provide a strong framework for improving care, their success depends heavily on **adequate funding, workforce capacity, and patient engagement**. In practice, implementation can be challenging, particularly in **under-resourced areas**.

POLITICAL AND POLICY CONTEXT

Diabetes management and prevention in the UK are shaped by **national policies** and **government priorities**. The **Department of Health and Social Care** and the **NHS Long Term Plan** focus on preventing **Type 2 Diabetes**, enhancing **digital health**, and integrating **primary care, community services, and hospitals** (NHS England, 2023). Key initiatives include:

- **Continuous glucose monitoring (CGM):** Allows individuals who have **Type 1 diabetes** or who have **Type 2 diabetes** and use insulin to monitor **blood glucose levels**, improving **glycaemic control** and **clinical decision-making** (Beck et al., 2021).

- **Targeted screening and prevention programmes:** **High-risk individuals** are offered screening and access to the **NHS Diabetes Prevention Programme**, supporting **lifestyle changes** and **early intervention** (Valabhji et al., 2020).

- **Digital health and telemedicine innovations:** **Apps, remote monitoring, and online consultations** increase access for those with barriers to **in-person care** (Greenhalgh et al., 2020).

Despite these strategies, practical delivery often lags due to **workforce shortages, regional variation, and limited funding**. Addressing broader **social and environmental factors**, like **poverty** and

limited availability of healthy food, sedentary lifestyles, and healthcare inequalities, is essential. Policies focused only on **medical treatment** may not significantly reduce **Type 2 Diabetes prevalence** (Public Health England, 2021; Bambra et al., 2021).

However, despite strong **policy commitments**, there is often a gap between **policy and practice**. Variations in **local implementation, limited resources**, and ongoing **health inequalities** reduce the overall effectiveness of these initiatives.

RECOMMENDATIONS FOR IMPROVED CARE

Improving diabetes care requires a **person-centred approach** that considers **individual needs, culture, and lifestyle**. Key recommendations include:

- **Culturally tailored education:** Provide diabetes information that reflects patients' **language, diet, and cultural beliefs**. This improves **understanding** and encourages **healthier lifestyle choices** (Wilding et al., 2020; Lingvay et al., 2022).
- **Psychological support:** Include **mental health screening** in annual diabetes reviews to detect **anxiety, depression, or diabetes-related distress**. Early support helps improve both mental **well-being** and glycaemic control (Fisher et al., 2021; Holman et al., 2021).
- **Community-based prevention:** Offer local programmes such as **walking**

groups, healthy cooking classes, and weight management sessions. These initiatives make **prevention accessible** and increase **community engagement** (Valabhji et al., 2020).

- **Digital inclusion:** Ensure patients can access **apps, remote monitoring, and online consultations**. Provide **training and support** for those unfamiliar with technology to reduce barriers to care (NHS England, 2022).
- **Early remission programmes:** Support structured **weight management programmes** for individuals with **Type 2 Diabetes**. Early intervention can reduce **medication dependence** and sometimes put the **condition into remission** (McCombie et al., 2021).

SELF-MANAGEMENT AND END-OF-LIFE CARE IN DIABETES

Self-management is a **fundamental component** of effective diabetes care, particularly for individuals with **Type 2 Diabetes**. It includes patients actively controlling their condition by monitoring **blood glucose levels**, following **medication plans**, maintaining a **healthy diet**, and engaging in **regular exercise**. **Structured education programmes** and **personalised care planning** can improve patients' **knowledge, confidence**, and ability to make **informed decisions** about their health. This approach supports better **glycaemic control** and reduces the risk of **long-term complications** (Powers et al., 2020; Davies et al., 2022).

End-of-life care is an important but often overlooked aspect of diabetes management.

Individuals with **advanced complications**, such as **cardiovascular disease**, **kidney failure**, or **severe frailty**, may require a shift in treatment goals from strict **blood glucose control** to **comfort** and **quality of life**. Care should focus on avoiding **hypoglycaemia**, reducing **treatment burden**, and maintaining **dignity**. **Glycaemic targets** are often relaxed, and **medication regimens** may be simplified. **Palliative care teams** play a key role in supporting both patients and their families by addressing **physical, emotional, and psychological needs**. A person-centred approach ensures that care aligns with the patient's preferences and improves quality of life in the final stages (NICE, 2022; NHS England, 2023).

CONCLUSION

Diabetes Mellitus is a common and growing **chronic condition** impacting a considerable portion of the population in the **United Kingdom** (NHS England, 2023; Diabetes UK, 2023). **Type 2 Diabetes**, largely related to **lifestyle** and **social influences**, is the most frequently occurring form, while **Type 1 Diabetes** necessitates **lifelong insulin** use

(NICE, 2022). Both types can have serious **physical, psychological, and social impacts** if not managed effectively (WHO, 2023).

Effective management relies on a combination of **healthy lifestyle changes, medication, education, and self-management support** (NICE, 2022). **Person-centred care**,

community programmes, and **structured models** such as the **House of Care** help patients take control of their **health** and improve **long-term outcomes** (NHS England, 2021). **National policies**, **prevention programmes**, and **digital innovations** provide frameworks for **better care**, but **practical implementation** requires addressing **social inequalities** and supporting patients in their **daily lives** (Department of Health and Social Care, 2022; Public Health England, 2021).

By focusing on **early prevention**, **personalised care**, and **community engagement**, diabetes can reduce **complications**, improve **quality of life**, and ease the burden on **healthcare services** (NHS England, 2023). However, without addressing underlying **social inequalities** and ensuring **consistent implementation** of policies at the **local level**, improvements in diabetes outcomes may remain **limited**. **Empowering patients and communities** remains the key to managing diabetes successfully and building healthier futures (WHO, 2023).

REFERENCE

- American Diabetes Association (2023). *Standards of Care in Diabetes—2023*. Diabetes Care, 46(Suppl.1), pp. S1–S291.
- Bambra, C., Riordan, R., Ford, J. and Matthews, F. (2020). The COVID-19 pandemic and health inequalities. *Journal of Epidemiology and Community Health*, 74(11), pp.964–968.
- Beck, R.W., Riddlesworth, T., Ruedy, K., Ahmann, A., Bergenstal, R., Haller, S., Kruger, D., McGill, J.B., Polonsky, W., Toschi, E., Wolpert, H. and Price, D. (2017). *Effect of continuous glucose monitoring on glycemic control in adults with type 1 diabetes using insulin injections*. JAMA, 317(4), pp.371–378.
- Davies, M.J., Aroda, V.R., Collins, B.S. et al. (2022). Management of hyperglycaemia in Type 2 diabetes. *Diabetologia*, 65(12), pp.1925–1966.
- Department of Health and Social Care (2022). *Integration and innovation: Working together to improve health and social care*. London: DHSC. Available at: <https://www.gov.uk> (Accessed: March 2026).
- Diabetes UK (2023). *Diabetes prevalence 2023*. Available at: <https://www.diabetes.org.uk> (Accessed: March 2026).
- European Society of Cardiology (2021). *2021 ESC Guidelines on cardiovascular disease prevention in clinical practice*. European Heart Journal, 42(34), pp.3227–3337.
- Fisher, L., Gonzalez, J.S. and Polonsky, W.H. (2021). The confusing tale of depression and distress in patients with diabetes. *Diabetic Medicine*, 38(2), pp.1–8.
- Greenhalgh, T., Wherton, J., Shaw, S. and Morrison, C. (2020). Video consultations for COVID-19. *BMJ*, 368, pp.1–5.
- Holman, N., Young, B. and Gadsby, R. (2021). Current prevalence of Type 1 and Type 2 diabetes in adults and children in the UK. *Diabetic Medicine*, 38(1), pp.1–7.
- Holt, R.I.G., DeVries, J.H., Hess-Fischl, A., Hirsch, I.B., Kirkman, M.S., Klupa, T., Ludwig, B., Nørgaard, K., Pettus, J.H., Renard, E., Seaquist, E.R. and Weinstock, R.S. (2021). *The*

management of type 1 diabetes in adults: A consensus report by the American Diabetes Association and the European Association for the Study of Diabetes. Diabetes Care, 44(11), pp.2589–2625.

International Diabetes Federation (2023). *IDF Diabetes Atlas (10th ed.)*. Brussels: International Diabetes Federation. Available at: <https://www.diabetesatlas.org> (Accessed: March 2026).

Kar, P., Martin, C., McGovern, A., Stribling, B., Besser, R.E.J., and Misra, S. (2022). *Uptake and impact of the NHS Diabetes Prevention Programme: A systematic review*. Diabetic Medicine, 39(2), e14764.

Lingvay, I., Sumithran, P., Cohen, R.V. and le Roux, C.W. (2022). *Obesity management as a primary treatment goal for type 2 diabetes: Time to reframe the conversation*. The Lancet, 399(10322), pp.394–405.

Marmot, M. (2020). *Health equity in England: The Marmot review 10 years on*. London: Institute of Health Equity. Available at: <https://www.health.org.uk> (Accessed: March 2026).

McCombie, L., Leslie, W., Taylor, R., Kennon, B., Sattar, N., Lean, M.E.J. (2021). *Beating type 2 diabetes into remission*. BMJ, 374, n1449.

National Institute for Health and Care Excellence (2022). *Type 2 diabetes in adults: Management (NG28)*. London: NICE. Available at: <https://www.nice.org.uk> (Accessed: March 2026).

NHS Digital (2023). *National Diabetes Audit report 2023*. Available at: <https://digital.nhs.uk> (Accessed: March 2026).

NHS England (2021). *The House of Care framework for long-term conditions*. London: NHS England. Available at: <https://www.england.nhs.uk> (Accessed: March 2026).

NHS England (2022). *Digital health and remote monitoring in diabetes care*. London: NHS England. Available at: <https://www.england.nhs.uk> (Accessed: March 2026).

NHS England (2023). *NHS Diabetes Prevention Programme: Progress report*. London: NHS England. Available at: <https://www.england.nhs.uk> (Accessed: March 2026).

Office for Health Improvement and Disparities (2023). *Health inequalities: Diabetes prevalence, risk factors and complications*. London: Department of Health and Social Care. Available at: <https://www.gov.uk> (Accessed: March 2026).

- Powers, M.A., Bardsley, J., Cypress, M. et al. (2020). Diabetes self-management education and support in adults with Type 2 diabetes. *The Diabetes Educator*, 46(4), pp.350–369.
- Public Health England (2021). *Health inequalities and diabetes: risk factors, prevalence and outcomes*. London: Public Health England. Available at: <https://www.gov.uk> (Accessed: March 2026).
- Sinclair, A., Abdelhafiz, A.H. and Rodriguez-Mañas, L. (2020). Diabetes and frailty in older people. *The Lancet Diabetes & Endocrinology*, 8(10), pp.870–880.
- Sun, H., Saeedi, P., Karuranga, S., Pinkepank, M., Ogurtsova, K., Duncan, B.B., Stein, C., Basit, A., Chan, J.C.N., Mbanya, J.C., Pavkov, M.E., Ramachandaran, A., Wild, S.H., James, S., Herman, W.H., Zhang, P., Bommer, C. and Williams, R. (2022). *IDF Diabetes Atlas: Global, regional and country-level diabetes prevalence estimates for 2021 and projections for 2045*. Diabetes Research and Clinical Practice, 183, 109119.
- UK Health Security Agency (2022). *Health inequalities in diabetes: Risk factors, prevalence and outcomes*. London: UKHSA. Available at: <https://www.gov.uk> (Accessed: March 2026).
- Valabhji, J., Barron, E., Bradley, D. et al. (2020). Early outcomes from the NHS Diabetes Prevention Programme. *Diabetic Medicine*, 37(9), pp.1529–1538.
- Wilding, J.P.H., Batterham, R.L., Calanna, S., Davies, M., Van Gaal, L.F., Lingvay, I., McGowan, B.M., Rosenstock, J., Tran, M.T.D., Wadden, T.A., Wharton, S., Yokote, K., Zeuthen, N. and Kushner, R.F. (2021). *Once-weekly semaglutide in adults with overweight or obesity*. **New England Journal of Medicine**, 384(11), pp.989–1002.
- World Health Organization (2023). *Diabetes Fact Sheet*. Available at: <https://www.who.int> (Accessed: March 2026).