

LCHS7003

Understanding and Managing Type 2 Diabetes in the UK

An evidence-based information booklet for healthcare professionals: impacts, treatments, care models and practical improvements

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LCHS7003 | Community Care and Management of Longer-term Conditions

Component 1

Information Booklet of Long- term Condition Management



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1. Purpose and scope



Type 2 diabetes mellitus (T2DM) is a chronic metabolic condition characterised by high blood glucose levels caused by impaired insulin action and progressive insufficiency of insulin secretion. Commonly, it requires ongoing monitoring, management of risk-factor and adjustments to care over many years. For UK healthcare professionals, diabetes management involves more than glucose (blood sugar level) control. Heart and kidney problems, mental health issues, unequal access to healthcare and difficulties with treatment can affect patients' health, daily lives and overall well-being.

This booklet examines evidence relevant to the NHS practice that include physical, psychological and social consequences; treatments; two models of care; implementation of UK policy; and practical improvements. Focus is adults with T2DM and observational studies show possible links, not definite causes. Clinical trials are assessed to see whether their findings apply to different patients and match with their treatment choices.

2. Epidemiology, aetiology and burden

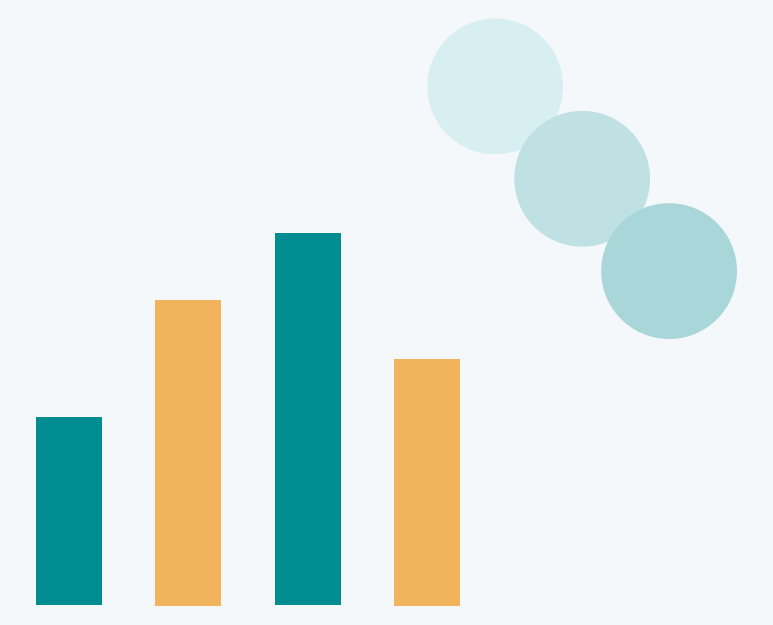


T2DM develops due to a combination of family history, the body not using insulin properly as well as reduction in insulin production and lifestyle and social factors. Relevant risk factors include family history, age, prior gestational diabetes, ethnicity, deprivation, physical inactivity and aspects of diet and adiposity. Diabetes risk does not depend only on personal choices. Income, working conditions, available healthy food and access to healthcare services can limit people's choices. Therefore, this is an ethical, clinical useful review to avoid blame and asks what kind of support is realistically available to each person.

According to International Diabetes Federation (2025), 589 million adult of aged 20-79 (11.1%) were living with diabetes worldwide in 2024, that include diagnosed and undiagnosed cases of all types, it projects 853 million by 2050. In the UK, Diabetes UK (2025) reported 4.6 million people with diagnosed diabetes, of whom approximately 90% had type 2, and an estimated 1.3 million people with undiagnosed T2DM. A separate 6.3 million people were estimated to have prediabetes, which must not be added to diabetes rate. Due to differences in age ranges, case detection, population coverage and estimates, it explains why these figures should not be compared as equivalent measures. These distinctions matter for resource planning and undiagnosed cases can lead to an underestimate of healthcare needs for early programme, while prediabetes with diagnosed disease can exaggerate existing diabetes caseloads.

Holman et al. (2025) investigate deaths and hospitalisation trends for heart and blood vessel, kidney and liver conditions among people with T2DM in England and analyses service demand that affected by coding, changes in treatment for the period 2009 – 2019. Panchal et al. (2025) examine ischaemic and non-ischaemic heart failure in a large English group, and underline why heart and blood vessel pressure must be considered beyond myocardial infarction alone. Goldney et al. (2026) examine ethnicity and age at diagnosis in England and provides a basis to ask whether prevention and screening are targeted while to avoid assumptions about individual risk from group membership.

2. Epidemiology, aetiology and burden



Alarcón-Yaquetto et al. (2026) examine economic pressure in relation to social determinants, while Martin et al. (2026) check an NHS remission pathway in economic way. Economic pressure includes things like medicines, checking, health problems, admissions, time away from employment and unpaid family support. For practitioners, key implication is to check both medical risk and financial or practical costs that treatment imposes on patients and services.

Further, research-method consideration is the difference between rate and number of new cases. Prevalence/rate refers to the proportion of people living with diabetes at a given time and can increase when survival improves, even if rate of new diagnoses does not. Comparisons across countries also depend on case-finding and health-system access. Therefore, professional should avoid interpretation of a higher recorded rate as evidence of poorer prevention. Similarly, ethnicity reflect a combination of social, environmental and biological factors of complex structural, environmental and biological influences. In local, it needs to review national surveillance with community engagement and deprivation sensitive service data.



3. Biopsychosocial consequences for individuals and families

3.1 Physical consequences: Persistent dysglycaemia and cardiometabolic risks contribute to cardiovascular disease, kidney impairment, neuropathy, retinopathy and diabetic foot disease. These outcomes interact as frailty and multimorbidity rather than isolated complications. Neal et al. (2026) investigate frailty, foot ulceration and mortality in UK primary-care record. Their multistate observational approach can illuminate patterns of progression, but remaining factors that may influence the findings and quality of routine code limit causal inference. Similarly, Panchal et al. (2025) and Holman et al. (2025) justify proactive assessment of cardiac, renal and broader organ risks, while their observational designs cannot alone establish which intervention will work best for an individual. With several health conditions, taking medicines are more difficult that also meet treatment goals more stressful.

3.2 Psychological consequences: Daily treatment decisions, uncertainty about complications, and experiences of stigma contribute to diabetes distress, anxiety or depression. Diabetes distress is not the same as a diagnosed mental health condition: both require attentive assessment and appropriate responses. Gillett et al. (2026) explore depression and treatment progress using UK primary-care data. Although such records reveal associations at scale, while documented diagnoses underestimate unmet need of mental-health. Ioannou and Papachristou Nadal (2026) focus on well-being of midlife women with T2DM through qualitative research. This method provides detailed information that medical records may miss, but same findings may not apply to everyone. Diabetes care should include mental health checks during regular appointments, and should not seem them as less important.

3.3 Social consequences: Ekpore et al. (2026) focus on to address diabetes related stigma in healthcare and professional implication is to use non-judgemental language, as well as ask about practical barriers. Alarcón-Yaquetto et al. (2026) also provide perspective on economic burden and social determinants. However, research on social differences must consider needs of local people's, as care available in a well-funded clinic may not be available in other areas. Overall, employment patterns, shift work, transport, housing, access to healthy food and cost of living may affect attendance, and opportunities for self-care.



3. Biopsychosocial consequences for individuals and families

3.4 Families and informal carers: Tang et al. (2026) examine family influences on self-management, and Matrook et al. (2025) investigate family-based interventions. Factors such as confidentiality, patient consent, relationship dynamics and unequal care services burden contribute in guided decisions.

The biopsychosocial model discussed in the module also helps healthcare professionals to understand effect of physical health, mental health and social circumstances. It is more than these three checklist. Due to depression, it could be harder to take medicines, insecure jobs can prevent clinic visits, and nerve damage can affect movement and social activities. Therefore, only blood sugar targets cannot show whether care meets a person's needs.

Another problem is that healthcare services treat each illness separately, while patients manage all of their health problems together. Many appointments, medicines, and conflict advice can be difficult for people who also work or care for family members. More of visits to healthcare services do not always mean patients are managing their conditions poorly. Limited access, numbers of illnesses and poorly connected services could be contributing factors. Healthcare professionals should also consider patients' strengths, such as family support, and difficulties, including loneliness or unclear information. They should agree on practical goals with patients.

4. Evidence-based NHS treatment and management



Evidence-based NHS management should help to manage patient blood sugar along-with prevention of heart disease, kidney problems, foot problems, eye damage and our complications. NICE NG28, recommends modified-release metformin with an SGLT2 inhibitor for adults with T2DM who have no related health conditions, unless these medicines are unsuitable or cause problems (National Institute for Health and Care Excellence, 2026). This also differs from previous guidance such as suggested metformin alone as the first treatment. NICE also advises healthcare professionals to discuss treatment choices, healthy habits, possible risks and personal wishes with patients. However, treatment must suit and align as per need of each person. Age-related weakness, kidney health, other illnesses, side effects, costs and personal goals can affect decisions. Healthcare professionals should check the complete guideline before the choice of treatment.

Nong et al. (2025) review research on different diabetes medicines, while McGuire et al. (2025) study oral semaglutide that affects heart health in patients at higher risk. Clinical trial help to show whether treatments cause improvements, but results from chosen participants may not apply in equal to weaker patients or those with several illnesses. Healthcare professionals should consider both benefits and side effects. Masnoon et al. (2017) also explain that rely on numbers of medicines does not always mean treatment is unsuitable. Overall, medicine choices should focus on benefits and important to patients, not only blood sugar results.

Mueller et al. (2025) evaluate the GLoW programme through a randomised trial, while Morris et al. (2025) investigate a digital support dietary intervention. It means that non-pharmacological support also matters. Trial design can help to identify effects of intervention, but recruitment and digital access may also influence who benefits. Education, nutrition support and appropriate physical activity should be adopted as per circumstances and health status, rather than framed as universal prescriptions.

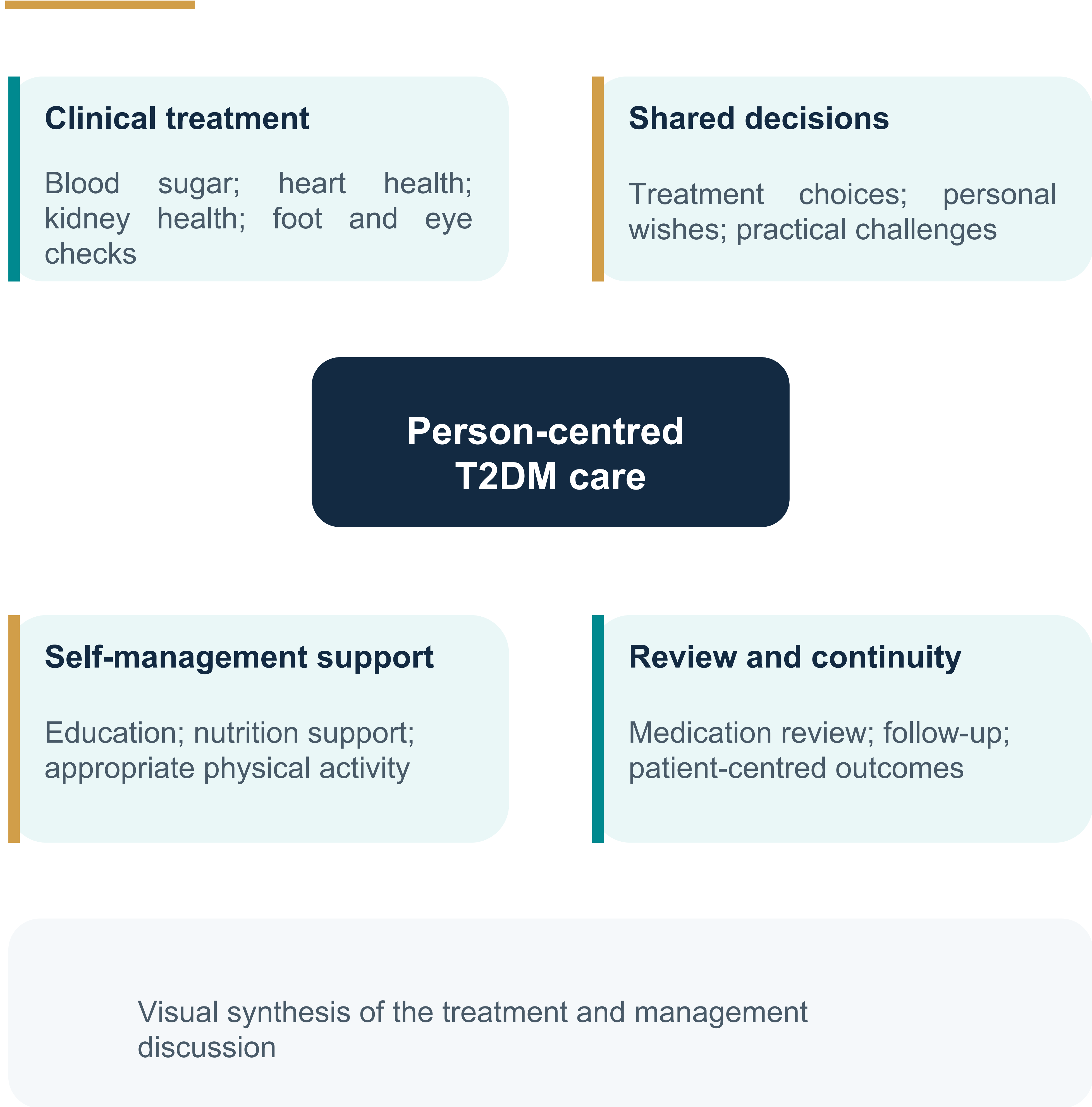
4. Evidence-based NHS treatment and management



Zafar, Scarlata and Jaleel (2026) study chronic kidney disease in UK primary care, and Muller et al. (2026) examine NICE guidance related to SGLT2 inhibitors. These implementation-oriented sources invite scrutiny of code, continuity, workforce capacity, and equitable prescribe. Regular medication review is important in multimorbidity: evidence-based drug may be beneficial but treatment burden can undermine a plan without joint negotiation.

Healthcare professionals should assess both clinical results and outcomes that affect patients' lives directly. Improvement in HbA1c levels do not mean less hospital admissions, longer survival or better quality of life. During research, professionals should consider absolute benefits, follow-up periods, potential side effects and whether study participants reflect patients is receiving community care. In case, decisions to increase treatment, it should involve shared decision-making, with clear discussions about expected benefits, practical challenges and individual patient priorities. This approach supports evidence-based, person-centred care along-with recognition of the needs and circumstances of each patient.

Diabetes care: connected priorities



Sources: NICE (2026); NHS England (2019).

5. UK and international care models



5.1 UK model: NHS England (2019) focus toward shared decision-making, personalised care and support plan, enable choice, social prescribe, support self-management and personal health budgets as interconnected elements. NHS support self-management guidance and emphasises on knowledge, skills and confidence, while Coulter, Roberts and Dixon (2013) focus on to place collaborative care plan at the centre of the House of Care. When applied to T2DM, clinicians would agree on treatment goals jointly, through appropriate education and community support and review barriers such as language, working hours or transport. Its strength is attention to the whole person; its weakness is dependence on limited staff time.

5.2 International model: According to Wagner (1998), CCM is a healthcare approach that brings patients, healthcare professionals and community services together to improve long-term condition management through planned care, support of self-management, and regular follow-up. It means that Chronic Care Model (CCM) links informed people and Healthcare professional teams through self-management support, clinical information systems, decision support, community connections and healthcare organisation. Grover and Joshi (2015) reviewed chronic disease models and identify CCM as the most frequent evaluated model in their included studies, while warn that evidence varies across populations. When applied to T2DM, a team could use registers to recall people for reviews, follow up abnormal results, as well as coordinate medication changes and refer to education. This model addresses fragmented services but does not remove unequal access or guarantee that each consultation should consider needs of individual patient's, preferences and treatment goals.

5. UK and international care models



NHS personalised-care approach prioritises autonomy, goals and community support; CCM highlights that organisational conditions needed to deliver planned and reliable follow-up. Peimani et al. (2025) explore shared decision-making perspectives, while Wang et al. (2025) evaluate an international community-based integrated diabetes-depression care model; these studies also address different parts of effective care and cannot establish overall framework is superior in the NHS. Evaluation should include implementation indicators and patient-centred outcomes. Examples include continuity with a named professional, completion of joint agreed reviews, referral uptake, involvement of reported decision, complication-related admissions and variation across deprivation groups. All of these measures answer different questions: a high review-completion rate indicates good processes.

5. UK and international care models

5.1 UK model

- NHS personalised care
- Shared decision-making
- Personalised care and support plan
- Supported self-management
- Social perspective and community support

5.2 International model

- Chronic Care Model (CCM)
- Planned care and regular follow-up
- Clinical information systems
- Decision support
- Community connections

Common purpose

Better long-term condition management through coordinated care and self-management support

Sources: NHS England (2019); Wagner (1998); Grover and Joshi (2015).

6. Policy and Implementation in UK services



NICE NG28 (National Institute for Health and Care Excellence, 2026) sets clinical standard for adults with T2DM; NHS England (2019) describes national ambitions for personalised care, supported self-management and local service coordination. 2019 NHS Long Term Plan also highlights prevention, community care and health inequalities. Older policies are relevant as historical foundations. Diabetes UK (2025) identifies large numbers of people with undiagnosed T2DM and strengthen the case to improve access for diagnosis and follow-up. Local integrated care boards and practices are required to transform national priorities into measurable services.

Tahir et al. (2025) investigate implementation of NICE NG28 and provide a useful lens on the difference between guideline publication and changes in routine practice. Muller et al. (2026) consider uptake of SGLT2 inhibitor recommendations, while Zafar, Scarlata and Jaleel (2026) address chronic kidney disease in primary care. At service level, Malloy et al. (2025) examine the North East Essex Diabetes Service, and Marsden et al. (2026) investigate the NHS Healthy Living programme. Their relevance is practical: local integration and digital education should be judged by participant, based on whether outcomes improve and whether benefits are maintained. Goldney et al. (2026) foreground ethnicity and diagnosis age, reinforce the need to stratify service evaluations by population group rather than rely on averages. Martin et al. (2026) focus on to add economic perspective for an NHS remission pathway. Moreover, cost-effectiveness is necessary for responsible commission but it does not settle ethical questions about accessibility, patient burden or distribution of benefits.

A critical policy conclusion is that national guidance is a necessary to support equitable diabetes care. Local workforce capacity, language support, digital inclusion, transport, referral pathways and collaboration with social care affect whether evidence reaches for patients. Commissioners and clinical teams should monitor both clinical indicators and inequalities in service uptake, using patient-reported experience to explain gaps that administrative data cannot.

6. Policy and Implementation in UK services



A practical way to improve care would be to create a local dashboard that tracks differences in healthcare outcomes and patient experiences. It could monitor attendance in diabetes education, goals in agreed care, checks in kidney and foot, heart health, difficulties in treatment, language support and preventable hospital admissions across different patient groups. Although this would not explain the causes of inequalities, but it could highlight problems that overall results may hide. Healthcare professionals and patients should work together to choose what to measure and understand these differences before improvements. The dashboard would also need accurate records, data protection and regular reviews to ensure it improves care rather than paperwork.

7. Recommendations



Following are the recommendations:

Embed shared decision-making in every substantive diabetes review. Ask patient to identify the outcomes that matter most. Also, explain benefits and harms in understandable terms, and document a negotiated plan. Peimani et al., (2025) also provide a relevant perspective on shared decisions; NHS personalised-care framework provide an operational route. Audit not only whether a care plan exists but whether patients report involvement and understand what happens next.

Integrate psychological and social assessment with routine clinical care. Screen for distress and depression, enquire about food security, work patterns and medicine access, and provide clear routes to psychological or social support. Gillett et al. (2026), (Ioannou and Papachristou Nadal (2026), and Ekpor et al. (2026) support relevance of these domains. Implementation also requires protected review time, staff training and accessible referral options; without these, screening can also identify needs that services cannot meet.

Provide cultural response and family-sensitive self-management support. Hadziabdic and Hjelm (2025) explore cultural appropriate diabetes education; Matrook et al. (2025) synthesise family-based interventions, and Tang et al. (2026) and Zhang et al. (2026) examine family or dyadic support. Invite family participation only with patient permission, and provide accessible language and literacy support. Corben and Rosen (2005) also show that willingness and capacity to self-manage can change with diagnosis, illness and life circumstances; professionals must not mistake low engagement for a lack of concern.

Make digital support optional and equitable. Morris et al. (2025), Mahfuza et al. (2025), Marsden et al. (2026) and Eisa and Barood (2026) explore digital enable care or interventions. Services should retain telephone and face-to-face routes, and provide digital assistance where useful, and monitor participation by age, language, disability and deprivation. Digital engagement is a process measure toward improved health.



7. Recommendations

Adjust care to change priorities across life course. People who are frail, have several serious health conditions or may have limited time to live could benefit from the review of their medicines and how often they need health checks. These decisions should reflect like benefits and personal wishes. Weerasinghe et al. (2025) discuss that diabetes care for people with advanced cancer, does not mean treatment should be reduced for everyone with T2DM. National Institute for Health and Care Excellence (2015) and the module resource Planning for your future care also encourage sensitive conversations about comfort and future care choices when appropriate. Patients should remain involved in decisions whenever possible, and families should participate as per patients' wishes. Care plans should be recorded and reviewed as change in needs.

8. Conclusion



Type 2 diabetes care in the UK requires clinical treatment and attention to the social and psychological conditions that affect whether care works. Recent studies also focus on to add evidence on complications, therapies, inequalities and delivery, but findings vary by population, design and outcome. 2026 NICE update also strengthen the case for cardiovascular and renal protection alongside individualised goals. NHS personalised-care approach and organisational strengths of the Chronic Care Model also provide a reasoned way to improve continuity and fairness. Local teams should test changes using meaningful patient outcomes and equity measures rather than to assume that a policy or intervention is effective merely because it has been introduced.



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