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Utilisation of Group-Based Diabetes Education Programmes: Perspectives of Healthcare Practitioners

Muili Olugbenga Lawal [1,*], Anthony Woodman [2], Farouk Ayodeji Lawal [3] and Hameedat Olajumoke Omobayo [4]

[1] College of Nursing, Midwifery and Healthcare, University of West London, Paragon House, Boston Manor Road, London TW8 9GA, UK
[2] Office of the Vice-Chancellor, University of Hertfordshire, Hatfield AL10 9AB, UK
[3] NHS England, London SE1 8UG, UK
[4] Northamptonshire Healthcare NHS Foundation Trust, Northamptonshire NN15 7PW, UK
* Correspondence: muili.lawal@uwl.ac.uk

Abstract

Background: Structured patient education (SPE) is a critical component of diabetes management, with the potential to reduce its physical, social, and economic burden. National and international guidelines emphasise the importance of raising awareness and equipping individuals with the knowledge and skills necessary for effective self-management. In the UK, practice nurses are central to this effort, playing a key role in identifying at-risk individuals and facilitating referrals to diabetes education programmes. However, non-attendance at these programmes remains a persistent challenge, undermining the impact of policy initiatives and service provision. **Aim of the study**: This study aimed to explore practice nurses' perspectives on the factors contributing to non-attendance at diabetes education centres and to identify potential strategies to improve uptake. **Methods:** A qualitative approach was employed, involving semi-structured face-to-face interviews with eight practice nurses across six general practice (GP) surgeries in Southeast England. Data were analysed thematically to uncover key patterns and insights. **Results**: Findings reveal that barriers to attendance are multifaceted, encompassing personal, social, and systemic factors. These include limited patient understanding of the benefits of education, cultural and language differences, scheduling conflicts, and perceived relevance of the programmes. **Conclusions:** The results highlight the need for a coordinated, patient-centred approach that addresses these challenges through improved communication, flexibility in programme delivery, and enhanced interprofessional collaboration.

Keywords: self-management; structured diabetes education; concordance; health litracy; health economics; health promotion; qualitative study design

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1. Introduction

Diabetes remains a pressing global public health issue, with a growing prevalence that increasingly affects younger populations. The World Health Organization [1] estimates that approximately 830 million people worldwide are living with diabetes, reflecting a significant and sustained burden on healthcare systems. In the United Kingdom, current data from Diabetes UK [2] show that 5.8 million individuals are affected, with the financial implications equally substantial: the National Health Service (NHS) spends at least GBP 10.7 billion annually on diabetes-related care, and this is around 6% of its total budget [3,4]. The NHS is the publicly funded healthcare system in the United Kingdom, providing healthcare services to citizens based on individual need and free at the point of delivery.

Therefore, this rising cost highlights the urgency of effective prevention, early diagnosis, and long-term management strategies.

Contributing factors to type 2 diabetes include societal changes associated with industrialisation and globalisation, such as unhealthy diets and sedentary lifestyles [1]. The Ottawa Charter [5] and subsequent WHO reports [6] have long advocated for prevention and individual empowerment in health promotion. The United Kingdom National Institute for Health and Care Excellence (NICE) guideline for diabetes recommends Structured Patient Education to adults with type 2 diabetes and their family and/or carers with an annual update [7]. Globally, several policy initiatives over the past decade have emphasised the importance of self-management for people with diabetes [1,7,8]. Structured patient education (SPE) is a cornerstone of these efforts, aimed at equipping patients with the knowledge and skills to manage their condition effectively and improve their quality of life [9]. However, implementation of policy initiatives in the real-world environment may be challenging; therefore, implementation of diabetes structured patient education is not an exception.

The philosophical shift in care management for people living with long-term conditions has emphasised shared decision-making and patient empowerment. In the United Kingdom, there are several nationally accredited structured patient education programmes that are delivered in diabetes education centres—such as DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed), X-PERT, and DAFNE (Dose Adjustment for Normal Eating). Programmes like DESMOND are routinely offered to patients via automatic referral systems operated by practice nurses within primary care settings. DESMOND structured education is a six-hour group education programme offered in a single day or spread over two days [9]. These initiatives are designed to facilitate understanding, support behaviour change, and prevent complications. However, low attendance rates continue to undermine their effectiveness [4,10]. National data highlight that missed healthcare appointments cost the NHS approximately GBP 1.2 billion annually [11,12], further straining limited resources.

The NHS Long-term Plan (2019) document supports the importance of community-based diabetes healthcare provision, because these services are key to reducing hospital admissions, complications, and promoting self-care management. The issues associated with continuity of care during transitions between the primary and secondary care sectors such as poor communication and missed follow-ups are well documented in the literature [13–15]. Practice nurses play a pivotal role in referring patients to diabetes education services and supporting self-management initiatives in the community. Their unique position within the primary care team allows them to directly influence patient engagement [13,14]. Yet, the perspectives of practice nurses on barriers to attendance have been largely underexplored in the existing literature. Although some studies have examined barriers to attendance at diabetes education centres [4,11,16] little is known about the views of these frontline practitioners who are integral to implementing policy at the grassroots level.

Non-attendance is a menace that impacts the patient's health, result in waste of resources, affects the capacity to care for others, and increases the waiting list time [3,4,10,17]. This study aims to explore practice nurses' perspectives on the factors contributing to non-attendance at diabetes education centres and to identify practical strategies to enhance participation. By examining their insights, this research seeks to inform policy and service delivery improvements that support the national agenda for diabetes education and patient empowerment.

2. Research Design and Methods

This qualitative study used semi-structured interview study to explore the views of healthcare practitioners working in six General Practice (GP) surgery settings in South-east of England, United Kingdom. General Practice surgery is the first point of call for most non-emergency health problems within the National Health Service. They diagnose, treat a wide range of diseases and refer patients to hospitals and specialist services. The objective of the study was to explore the reasons for non-attendance at diabetes education centres and identify ways to improve attendance.

2.1. Study Population

A purposive sampling technique was used to recruit the participants from the selected GP surgeries. Both oral and written information was given about the purpose and design of the study, and eight practice nurses referring patients to the education centres agreed to participate in the study. The eligibility criteria include all participants who are working full-time in a General Practice surgery and have a minimum of 5 years working experience. These selection criteria ensured that the participants were engaging with patients affected by diabetes and have sufficient experience to provide adequate insight into the question of enquiry. The data were collected through semi-structured interviews by an experienced researcher (author 1) who has no personal or official relationship with any of the participants and none of the participants dropped out of the study.

2.2. Data Collection

A written question guide was used to facilitate the discussion, the format was an open-ended question, and this allows the participants to freely discuss their opinion. Interview technique was chosen to obtain information because this approach supports the aim of the study which was to explore their opinion and perceptions of the phenomenon of interest. The seven questions that were used as a guide to collect data for the study was developed based on literature review and the previous phase of the study. This face-to-face interview adopted a conversational style, and the answers were recorded on a tape recorder in addition to the notes taken during the conversation. The interviews were conducted in a private seminar room in the GP surgeries and the interview discussions ranged from forty to fifty minutes.

2.3. Ethical Implications

The research followed the principles outlined in the Declaration of Helsinki and was conducted according to ethical codes guiding research in the United Kingdom. The key ethical issues of significance for this research are informed consent, voluntary withdrawal, and confidentiality. The participants were given participant information sheet, and they all signed a consent form, hence, the research complies with the ethical guidelines in the United Kingdom.

2.4. Data Analysis

From interpretivist perspective, a descriptive approach was undertaken by using thematic analysis. The interviews were transcribed verbatim, and three researchers were involved in reading and rereading the interview data several times. The individual narratives from the semi-structured face-to-face interviews were anonymized and coded in four stages following level 1 coding with direct statements, level 2 coding with explanations and initial comments, level 3 coding which clustered the codes into sub-themes, and finally arrived at major themes in level 4 coding. The process and themes were agreed among the authors, and the findings from the qualitative data are summarised under the three themes listed in Table 1 below.

Table 1. Summary of findings.

Major Themes:	Sub Themes:
Organisation of care	- Organisational procedure - Service overload/waiting time - Limited time - Language barrier - Inconvenient time and location of the session - Perceptions and attitude of practitioners towards diabetes education
Personal circumstances and attitudes of patients to diabetes education	- Childcare issues - Personal dispositions - Forgetfulness - Motivation - Perceptions and belief about diabetes - Perceptions and beliefs about self-care - Preference for group education
Strategies to aid attendance	- Organisational adaptability and flexibility - Resources - Training and development - Collaborative practice

3. Results

The demographic shift in the incidence and prevalence of diabetes requires evolution of care that can meet the needs of the affected people. Addressing the knowledge gap by providing structured patient education may help, but attendance is required to unlock new thinking about diabetes self-management. While the evidence has shown the negative impact of non-attendance in diabetes education centres, the perceptions of practitioners in the primary care settings in the UK remain underexplored. All the participants were female, and this reflects the demography of General Practice nurses in the United Kingdom. They all had over ten years working experience, which has a positive implication for the outcome of the study in terms of their clinical experience. The findings of this study revealed three main themes: organisation of care, personal circumstances, and attitudes of patients to diabetes education, coupled with strategies to aid attendance (Table 1).

3.1. Theme 1. Organisation of Care

Globally, diabetes education is seen as a positive step, and practice nurses are positioned to aid its effective delivery, though this must be well organised to ensure its success. In this study, the participants viewed that organisation of care was an issue. Some participants felt that frequent organisational changes are impacting on their work:

> *'I have been practicing nursing for over 19 years and in the last couple of years we have had so many organisational changes such as the GP commissioning, Quality Outcome Framework changes, the Integrated Care Planning being brought in'*. (Participant 6)

3.2. Targets

There is evidence to support the use of QOF indicators to enable service improvements; however, there was a suggestion that the Quality Outcome Framework motivated some practitioners to increase their referral, but this does not translate to attendance:

> *'When QOF points came in, other less proactive GPs started firing off all these referrals for patients, so it overwhelmed the system'.* (Participant 3)

Some participants viewed that the new government regulations led to a longer waiting period between referral and invitation. Although longer waiting time could help the patients to plan their diary in advance, it has proved otherwise:

> *'There was a six month waiting list, and I think if there is a long wait, people will give up'.* (Participant 6)

Shockingly, some participants perceived referring patients to the diabetes education centre as a tick box exercise:

> *'And again, you have too many people walking in, and because we are being judged and the boxes need to be ticked'.* (Participant 1)

Regardless of the negative impact, a participant stated that the intention was good, and it serves a good purpose:

> *'I think it is a memory jogger so that when they are with us and we are going through the template at their diabetic review and have you referred them to the diabetes education programme pops up, that is our trigger'.* (Participant 2)

3.3. Limited Available Time

All the participants emphasised the issue of limited time:

> *'It really requires time, and time is one of the things we don't have, we are constantly fighting the clock so that is the problem as I see it'.* (Participant 6)

A participant shed more light on this issue by stating that the referral was often rushed due to lack of time and adequate information to guide their attendance was not always given:

> *'Yes, it's time—we need to cover so much when you don't know that person very well, unless you go through it fully, they will not understand'.* (Participant 8)

3.4. Impact of Language Barrier

Patient-practitioner communication is key to quality patient care; however, this can be impacted by factors such as lack of time and language barrier. Being a diverse population, some of the interviewees stated that lack of time could be compounded with poor level of English communication skills of the patients:

> *'Language is a barrier, for example, we have a lot of people with too many dialects'.* (Participant 3)

> *'We have language problems so that takes a lot of the time when somebody doesn't speak English, and I don't speak Punjabi or anything'.* (Participant 1)

3.5. Delivery of the Session

The practitioners' responses revealed barriers such as inconvenient date, location, and the length of the session:

> *'For working people in this area, there aren't classes in the evening or at weekends, and at a time when they could actually get to them'.* (Participant 7)

> *'The session is not run at different times, and they are quite long sessions'.* (Participant 4)

Group education is seen as a method to deliver diabetes health education for newly diagnosed patients; however, individual preferences differ:

> *'And they think oh that's too far and I may not feel comfortable mixing with other people and may not understand what they are saying'*. (Participant 2)

However, some participants expressed that some patients may like group education by saying:

> *'I found the elderly patients are more compliant. For example, if they live alone, it gets them out of the house to meet other people, and they may enjoy the programme'*. (Participant 8)

Again, it was felt that some patients do not like to travel while some patients like to stay in a familiar environment:

> *'Patients don't like to travel, they like to be in their own area with their own people'*. (Participant 4)

3.6. Individual Circumstances and Perceptions of Patients to Diabetes Education

Some patients may be prevented from attending the sessions due to personal problems which range from partner's sickness and mobility problems to a more chaotic life situation.

> *'Sometimes, it is health issues because they don't feel well enough to attend'*. (Participant 4)

> *'Life is too busy for a youngster and too chaotic'*. (Participant 6)

> *'With the elderly sometimes, it is transport and mobility'*. (Participant 8)

> *'I mean they have childcare problems'*. (Participant 7)

> *'I forgot or I was too busy, and life gets in the way'*. (Participant 1)

In contrast to personal difficulties, some practitioners thought that patients sometimes showed complete lack of interest in the session:

> *'And a lot of these patients just don't want to have diabetes, so they are very resistant to their diagnosis in the first place so anything else that they have to do on top of it, like just coming here, they are not at that point where they are willing to accept that'*. (Participant 8)

The psychological impact of the diagnosis may be compounded with the socio-cultural background of the patients which does influence their perceptions and consequently their healthcare decisions:

> *'Yes, health beliefs can be quite different, can't they, and I think some people can put their trust in herbal things. We have a guy who has a long history of diabetes from Asia, and he is convinced that chewing this leaf his mother gave him is going to take away his diabetes, and he's probably getting the hang of it now after about eight years'*. (Participant 5)

> *'A lot of my patients say to me oh my mother died of diabetes so they have a lot of wrong ideas about how diabetes can be treated, or maybe they don't even know it can be well managed'*. (Participant 1)

> *'Some of my patients will say they are borderline; therefore, they don't put enough effort'*. (Participant 7)

Incidentally, diabetes is an insidious disease; therefore, they do not feel sick at this stage:

> *'And they say to us well I don't feel ill… I haven't got diabetes as I don't feel ill'*. (Participant 2)

A participant stated that patients may abstain because:

> *'Some may believe that God brought the disease, and the GP has nothing to do with it'.* (Participant 4)

Again, some patients have the opinion that it is the responsibility of the healthcare practitioners to care for them:

> *'It's a sort of sideline because they don't see the importance of looking after themselves'.* (Participant 2)

With gestational diabetes, the attendance is significantly different, and the process is the same:

> *'I suspect some people have a very negative experience of any sort of class and may have had a bad time at school, and so if they hear that this is a class, it might just make them turn off'.* (Participant 4)

Motivation was seen as a key factor in attendance, and the practitioners viewed that some patients are not well motivated:

> *'Generally, some patients don't see it as part and parcel of their diabetes management'.* (Participant 2)

> *'Also, the issue of freedom of choice may affect their motivation to engage with the service'.* (Participant 5)

> *'Again, there is an issue with I have a choice, I know what I am doing; they think they know everything and don't really think about the decisions they are making'.* (Participant 7)

However, the level of motivation varies across patients with different social status and education, and wealth may influence attendance:

> *'The more educated and the more affluent are quite keen, and ask you about the education, and they want to be referred to find out about diabetes and get along with life'.* (Participant 8)

Conversely, some patients may decide to learn about the disease on their own:

> *'They go and actually research the information themselves, they may feel that they don't actually need an education programme'.* (Participant 8)

> *'A patient said he knew more... than they could teach him'.* (Participant 2)

However, unstructured self-managed education has its shortcoming:

> *'Some also think they can get information from friends, family, and internet. They even go to American Diabetes association website and Canadian Diabetes association website without checking or thinking that their approaches might be different from us'.* (Participant 6)

3.7. Strategies to Promote Attendance

The participants' view on ways to promote attendance was sought, and most participants emphasised the issue of accessibility such as practice-based education session:

> *'If the education was near to the patient and at a time they could go because a lot of the patients are working'.* (Participant 1)

> *'You know if the education is here, other practices in my locality would come here rather than go up to the main hospital or go to a very far community centre'.* (Participant 5)

> *'I'm sure they would come because they are already familiar with the GP surgery and then seeing old faces. They can see the nurse that they are used to, and they would know'.* (Participant 1)

To aid accessibility, some participants felt that:

> *'I think putting it at convenient times, so have evening sessions maybe a Saturday morning session'*. (Participant 6)
>
> *'They may need to do more sessions in the summer holiday'*. (Participant 4)
>
> *'I think it'll be far better to put energy into developing programmes so that people could either do an interactive online session, or have some sort of helpline available'* (Participant 5)

Increase in staffing level may provide additional time that is available for the practitioners to attend to the patients:

> *'Staffing of course, if there were twice as many nurses doing the job'*. (Participant 5)
>
> *'There is also the need for staff training'*. (Participant 3)

In contrast to strategies relating to the individual, organisation, and the Government, a participant identified the role of external agency in supporting the delivery of the programme:

> *'The big industries or companies could also help with education, instead of just sending different types of glucose meters all the time, they could help with things like translation of pamphlets to other languages because we are curtailed with finances'*. (Participant 3)

Some participants suggested prompt patient contact to sustain patients' interest:

> *'I think something like a welcoming letter or a phone call, and they would think oh they are expecting me, and someone is going to notice if I turn up or not, obviously they are more likely to attend'*. (Participant 8)

Some of the participants stated that non-compliance is a common phenomenon in the whole healthcare sector, suggesting the view that it does not matter:

> *'Non-compliance is always a problem. I see it every day, you see patients telling you that I don't take my water tablet when I am going out for a social event and you look down at their feet, it is very oedematous'*. (Participant 3)

Although, non-attendance can be frustrating to the healthcare practitioners, all the participants perceived the use of negative motivational technique such as imposing a sanction as counterproductive:

> *'I don't feel comfortable with sanctions as there must be a better way'*.
>
> *'I don't think any financial sanction will work; after all, the NHS is free'*. (Participant 7)

And some participants perceived it as a futile approach:

> *'I think there would be an outcry, a complete outcry; patients won't even pay their fine'*. (Participant 8)

Based on the thematic analysis, the findings of the study revealed a diverse range of factors that may either hinder or enhance attendance at the education centres. It is clear that every human being is unique; hence, individual circumstances are different and subject to change. The findings showed that all stakeholders involved have a pivotal role to play in enhancing effective strategies to aid attendance. Finally, it indicated that exploring ways to overcome the barriers identified in this data may enhance attendance. The graphical presentation of the results is shown below (Figure 1).

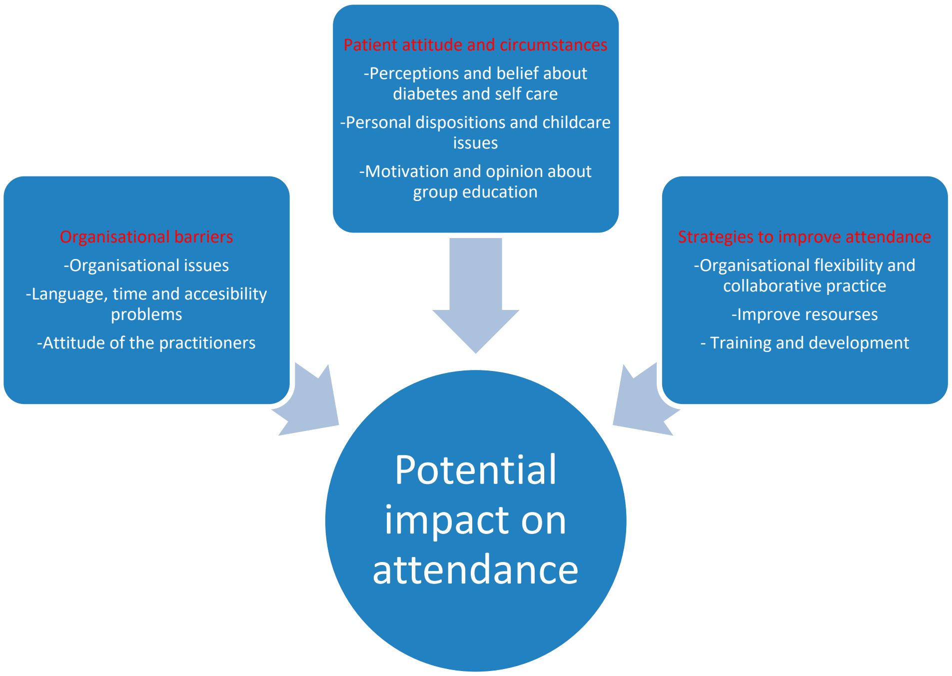

Figure 1. Graphical presentation of the results.

4. Discussion of Findings

Despite significant medical advancements, diabetes continues to pose a major global public health challenge, compounded by inadequate patient self-care practices. This study explored both systemic and patient-level factors that influence attendance at structured patient education (SPE) sessions. The findings reveal that barriers to SPE remain multifaceted, encompassing organisational, cultural, personal, and socioeconomic dimensions.

Organisational challenges, including inconsistent referral mechanisms, limited time availability, inadequate staff training, and bureaucratic hurdles, were frequently cited. These findings echo existing literature identifying similar systemic barriers [4,15,16]. Additionally, the influence of financial incentives and performance targets on healthcare delivery [17,18] raises concerns about the balance between regulation and quality patient care. Our findings support the need for regulatory reforms to reduce unnecessary administrative burdens while ensuring effective service delivery.

An important and unique insight from this research was the tension between promoting patient autonomy and meeting service delivery requirements. This balance was evident in healthcare professionals' narratives, suggesting that SPE must be adaptable to real-world constraints. Another novel finding was the proposed role of private industry in funding or supporting diabetes education, indicating a potential area for further investigation. This study confirmed that organisational protocols such as the timing, location, and mode of delivery of structured patient education significantly impact patient attendance. Participants highlighted how logistical factors, including lack of access to educational resources and inconvenient scheduling, serve as deterrents, corroborating earlier studies [19,20]. In addition, personal circumstances such as childcare responsibilities, health issues, and life crises were also shown to limit participation, in line with other findings [20,21].

The increasing use of digital technology in healthcare emerged as a promising but double-edged tool. While online education platforms offer flexibility, their effectiveness is hindered by the digital divide, especially among older adults and socioeconomically disadvantaged groups [22]. This aligns with broader concerns about digital exclusion in health service provision and emphasises the need for inclusive digital strategies. Participants also described patients' emotional responses to a diabetes diagnosis, particularly grief and denial, which influenced their lack of willingness to engage in education. The preference for informal sources of information (e.g., family and media) over formal sessions suggests a need for healthcare practitioners to better understand and address motivational and psychological barriers [23,24]. Also, the study highlighted that negative past experiences may foster resistance to education, emphasising the importance of compassionate and personalised practitioner-patient interactions. Socio-demographic disparities in attendance were reported due to the UK diverse population, and this further elucidates the importance of culturally competent care. Language barriers, cultural beliefs, and differing health literacies were found to impact access and engagement with structured patient education [16,21]. These findings reinforce NICE [7] recommendations that education programmes must be tailored to meet the cultural, linguistic, and cognitive needs of local populations.

Finally, the study revealed limited inter-professional collaboration, often hampered by poor communication between referrers and education providers. This lack of coordination, driven by bureaucratic targets and workforce shortages, hinders patient-centred care. The findings suggest that improved inter-professional communication and collaborative planning could address many organisational inefficiencies. Our findings identified some strategies such as flexible scheduling, diverse delivery methods, and increased resource allocation as potential solutions to improve attendance, as they align with the recommended best practice guidelines for diabetes education in the UK. However, implementation of these strategies remains constrained by ongoing NHS workforce shortages and funding limitations. Continuous professional development for staff is essential, yet financial constraints and workforce planning failures have made regular training difficult to sustain [25–27]. Spending cuts and staff shortages due to years of inadequate workforce planning and poor policy are now a well-recognized issue in the NHS. Addressing these systemic issues is crucial for long-term improvements in diabetes education and care delivery.

5. Strengths and Limitations of the Study

While some barriers to attendance at diabetes education centres have been previously documented, there remains a gap in the literature regarding the perspectives of practice nurses. This study addresses this gap by exploring the views of eight professionals. A key limitation of the study is the small sample size, therefore, future research could build on these findings by incorporating a larger and more geographically diverse sample. The use of purposive sampling from six General Practice surgeries allowed the study to target individuals with relevant experience, enhancing the relevance of the data collected. Also, the inclusion of only one professional group (practice nurses) limits the breadth of perspectives. Further studies should consider a multi-professional approach to gain a more comprehensive understanding of the issue. Although the sample size and sampling method may limit the transferability of the findings, the study maintained methodological rigour. This was achieved through audio recording, multiple coding by researchers, participant validation of transcripts, and ensuring data saturation [28,29]. Despite these limitations, this study contributes valuable insights into the barriers faced by patients and offers potential strategies to improve outcomes and satisfaction along the diabetes care pathway.

6. Summary

The NHS is currently facing significant challenges, including budget cuts, inflation, and an ageing population. Against this backdrop, the projected rise in diabetes prevalence adds further strain. One persistent issue is the high rate of non-attendance at clinical appointments, which negatively impacts care quality and leads to wasted resources. Various personal and systemic barriers, such as low self-efficacy, work obligations, motivation, and travel distance, contribute to the problem. The study also highlights concerns that current policies may prioritise regulation over patient needs. Nevertheless, sanctions for non-attendance are controversial given that the NHS is free at the point of use.

Diabetes education has the potential to significantly improve care, but individual circumstances often affect participation. Effective strategies must therefore operate across individual, professional, organisational, and governmental levels to bridge the gap between policy and practice. The evolution of diabetes education in the UK points towards a more holistic and effective model of diabetes management. This research offers valuable insight into how practice-level experiences can shape better implementation of diabetes education, ultimately enhancing patient outcomes and optimising healthcare resources. Looking ahead, future research should involve a larger, more geographically diverse sample across the UK and consider comparisons with healthcare systems that operate under different funding models.

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Institutional Review Board Statement: Ethical review and approval were waived for this study because, unlike research involving patients, studies involving healthcare practitioners working in England do not require ethics committee approval, provided that adequate information about the research is given and their consent is obtained. Although this is a continuation of a larger study, this phase does not require committee approval.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data available upon request.

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Conflicts of Interest: The authors declare no conflicts of interest.

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