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Conference over coffee: The initial type 2 diabetes consultation, and early-onset type 2 diabetes

The 2026 London Conference of the Primary Care Diabetes & Obesity Society took place on Wednesday 1 July at the Royal College of General Practitioners. Aligned with the newly updated NICE NG28 guidance, the programme focused on early intervention, multidisciplinary collaboration with the Integrated Neighbourhood Team, and practical strategies that empower individuals to self-manage their conditions and achieve better long-term health. In this short report, Pam Brown summarises the key take-home points from the first two sessions of the conference.

The initial consultation

See the person – the initial consultation and screening in primary care

Nicola Milne, Primary Care Diabetes Specialist Nurse, Manchester

- It is important to ensure the correct diagnosis, as there are many different types of diabetes and management differs accordingly.
- It may not be possible to classify the type of diabetes at onset; the priority is keeping the person safe.
  - Misdiagnosis occurs in up to 40% of adults with new type 1 diabetes.
  - Antibody and C-peptide testing may be required, and these take time.
- Remember monogenic diabetes (maturity-onset diabetes of the young; MODY) – specific gene mutation.
  - Usually age <25 years old.
  - Probability calculator and open-access education at: www.diabetesgenes.org.
- HbA_{1c} may be an unreliable measure of glycaemia in some situations, being falsely high or low. Some conditions can interfere with accurate assays.
- The Lyla's Law campaign is the important legacy from Lyla Story's missed type 1 diabetes diagnosis.
  - Remember the 4Ts: Toilet, Thirsty, Tired, Thinner. If any are present, suspect type 1 diabetes and check capillary blood glucose and ketones, and arrange immediate further assessment.
  - Type 1 diabetes incidence climbs through childhood, peaks at adolescence, steady incidence to mid-30s and then declines – but can present at any age.
- Suspect pancreatic cancer in people aged ≥60 years with weight loss and any of: back pain, diarrhoea, abdominal pain, nausea, vomiting or new-onset diabetes.
  - Arrange urgent direct-access CT scan (urgent ultrasound scan if no direct access to CT).

Resources

- Exeter University. MODY probability calculator and education resources
- Milne N, Thomas T (editors). *The Oxford Handbook of Diabetes Nursing* (2nd edition)
- PCDO Society. Diagnosis e-Learning module series
- *Diabetes & Primary Care* resources:
  - HbA_{1c}: Practicalities and pitfalls
  - At a glance factsheet: Recognition and management of pancreatogenic (type 3c) diabetes
  - At a glance factsheet: Diabetes and cancer
  - At a glance factsheet: Ketones and diabetes
  - How to correctly diagnose and classify diabetes

Helping people come to terms with a diagnosis of type 2 diabetes

Jane Diggle, Specialist Diabetes Nurse Practitioner, West Yorkshire

- The emotional and psychological side of diabetes is difficult to quantify and impacts quality of life.
- Diabetes stigma is defined as, "The adverse social judgment, stereotypes, and discriminatory attitude directed toward people living with diabetes because of having the condition" (Speight et al, 2024).
  - 80% of people with diabetes have faced negative attitudes, and 1 in 5 have faced discrimination.
  - Healthcare professionals may be a source of diabetes stigma.
  - Diabetes stigma impacts psychological, social and physical wellbeing.
- The initial consultation after diabetes diagnosis is a pivotal moment that shapes how someone perceives their condition and how they manage it.
  - Reactions to the diagnosis commonly include shock and disbelief, fear and

uncertainty, guilt and self-blame, stigma and shame, and loss of control/overwhelm.
  - How healthcare professionals communicate shapes long-term engagement, trust and outcomes.
- Language matters in every consultation – words have the power to harm or heal, to reinforce stigma or to promote engagement.
  - Non-verbal communication – tone of voice, facial expression – is important too.
- Clinicians can:
  - Acknowledge the emotional impact – validate emotions.
  - Normalise distress and uncertainty.
  - Explore what matters most to the person.
  - Reframe diabetes as manageable.
  - Collaborate on next steps.
  - Offer follow-up to reinforce continuity and support.
- Consultation tips to reduce blame, shame and bias:
  - Collaborative goal-setting: co-create a management plan.
  - Shift away from directives ("must, should, can't") to options ("could try this, consider that").
  - Normalise treatment escalation – progression is biological, not personal failure.
  - Pace information delivery – arrange early follow-up.

Further reading

- Speight J et al (2024) Bringing an end to diabetes stigma and discrimination: an international consensus statement on evidence and recommendations. *Lancet Diabetes Endocrinol* **12**: 61–82
- Turner M, Barton AH (2026) "See me, not my diabetes": A person-centred guide to better care. *Journal of Diabetes Nursing* **30**: JDN407

Resources

- NHS England. *Language Matters: Language and diabetes*
- Diabetes UK resources:
  - For healthcare professionals: Diabetes and Emotional Health – a practical guide for healthcare professionals supporting adults with Type 1 and Type 2 diabetes. Chapter 2 – Facing life with diabetes
  - For people living with diabetes: Coping with a diabetes diagnosis
- *Diabetes & Primary Care* resources:
  - How to help people come to terms with a diabetes diagnosis
  - How to find the ideal words in consultations

Early-onset type 2 diabetes

Type 2 diabetes management in a young person

Chirag Bakhai, GP, Luton

- Incidence of early-onset type 2 diabetes (EOT2D) – that diagnosed at age <40 years – is growing faster than onset aged 40–79 years. EOT2D is over-represented in people of minority ethnicity.
- EOT2D matters because:
  - Poorer cardiometabolic parameters and glycaemic progression.
  - Earlier development of complications.
  - More years of life lost due to diabetes:
    - 10–14 years in men and 11–16 years in women if diagnosed at age 30–40 years.
  - Adverse pregnancy outcomes and increasing prevalence of pregnancies complicated by type 2 diabetes.
    - Pregnancy preparation and maternal glucose levels during pregnancy have improved in women with type 1 but not type 2 diabetes.
    - Risk of serious adverse pregnancy outcomes is higher in pregnancies complicated by type 2 diabetes.
  - Despite the increased risks, people with EOT2D are less likely to:
    - Receive all 8 care processes than older people (47.3% aged 26–39 vs 66.6% aged 60–79 years).
    - Have glycaemia "to target" than older people.
- Beware the traps! Do not assume this is type 2 diabetes, that all medicines recommended in NICE NG28 are appropriate for every individual, or that the diabetes is the person's main concern.
- Practical framework for management:
  - Carefully consider if diagnosis is type 1 diabetes (same-day specialist review), type 2 diabetes or MODY, both at diagnosis and at each review – consider misclassification.
  - Contraception and planning for future pregnancy.
  - Psychological wellbeing and social support.
  - Optimise glycaemia, cardiovascular risk and weight.
    - More likely to be obese than older age groups.
    - Consider NHS Type 2 Diabetes Path to Remission Programme (45% remission rate if referred in first year from diagnosis), specialist weight management, structured education, group clinics.
- NICE (2026) NG28 guidance:
  - Offer modified-release metformin and an SGLT2 inhibitor. Consider triple therapy by adding a GLP-1 RA for cardiovascular, renal and glycaemic benefits, or tirzepatide for glycaemic benefits.
  - If metformin contraindicated or not tolerated, offer an SGLT2i and consider a GLP-1 RA or tirzepatide.
  - Set individualised targets together. Intensive glycaemic targets (<48 mmol/mol) are often appropriate with high lifetime risk. Avoid delay in escalation.

- Manage weight and blood pressure. Consider lipid-lowering therapy even if QRISK3 is low.

Resources

- EDEN: EOT2D toolkit
- NDA Young people with type 2 diabetes dashboard
- National Pregnancy in Diabetes Audit dashboard
- NHS Type 2 Diabetes Path to Remission Programme

Barriers to care in EOT2D

Rahul Mohan, GP, Nottingham

- People with EOT2D face triple barriers: higher lifetime risks associated with type 2 diabetes, harder engagement and unequal access to care (NICE, 2026).
- Clinical complexity and risk can be underestimated:
  - Very high lifetime risk of cardiovascular disease, renal complications and premature death.
  - Likely to be living with obesity.
  - Early intensive treatment is important, but the evidence is extrapolated as there are limited trials in EOT2D.
- Engagement, adherence and person-centred care barriers:
  - Stigma, stereotypes, blame, shame and guilt can undermine care.
  - Non-judgmental medication discussions are needed to support starting/continuing treatment.
  - Side-effects, treatment burden and practical barriers can reduce adherence.
  - Women of childbearing potential: pregnancy and fertility counselling around medications.
- System access and inequality barriers:
  - Education must fit cultural, linguistic, cognitive and literacy needs.
  - Lifestyle advice should be individualised and aligned with quality of life.
  - SGLT2 inhibitor uptake and technology access are currently unequal.
- Practice implications: barrier is whether the system delivers early intensive treatment, tailored education, non-judgemental conversations and equitable access to modern therapies and technology.
- Continuous glucose monitoring (CGM) can be used to help overcome barriers in diabetes management:
  - Reveals what HbA_{1c} hides: post-meal glucose spikes, overnight hypoglycaemia, glucose variability, treatment mismatch and lifestyle barriers (e.g. shift work).
  - Data capture provides insights, allowing coaching conversations and shared decision-making, action and review to improve outcomes.
  - Supports personalised coaching and education.
  - Helps overcome barriers with engagement (e.g. low motivation, poor understanding, hypoglycaemia fear, therapeutic inertia, stigma).
  - Helps identify treatment barriers.
- CGM can widen inequalities if access is not actively monitored and addressed.
- Barriers to implementing NICE NG28 are not only clinical but system-level, and include:
  - Inequitable access to and uptake of drugs.
  - Workforce capability and protected time.
  - Pathway fragmentation and inconsistent delivery.
  - Resource and capacity pressures.
  - Digital, data and monitoring challenges.
  - Personalisation complexity at scale – including shared decision-making and non-judgemental communication.

Resources

- NICE NG28: 2026 update
- PCDO Society. Type 2 diabetes remission: Toolkit for General Practice
- *Diabetes & Primary Care* resources:
  - The NICE NG28 type 2 diabetes guideline: Management update – what's new?
  - How to conduct an extended review for people with early-onset type 2 diabetes

References

NICE (2026) *Type 2 diabetes in adults: management* [NG28]. Available at: https://www.nice.org.uk/guidance/ng28

Speight J, Holmes-Truscott E, Garza M et al (2024) Bringing an end to diabetes stigma and discrimination: An international consensus statement on evidence and recommendations. *Lancet Diabetes Endocrinol* **12**: 61–82

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