Incretin therapies: Suitable for people with type 1 diabetes?

Thank you to Hannah Beba for her guest editorial last issue, in which she put forward a strong case for modern diabetes and obesity care to focus on meaningful, person-centred outcomes rather than rigid and narrow metrics. Concerns were again raised about lean mass loss with potent weight loss drugs and emerging evidence that weight cycling may be less harmful than assumed, reminding us of our role not just in initiating these agents but also providing support for long-term maintenance.

Dietary advice and support are important elements of what we do, although challenging for most healthcare professionals because of limited training, lack of conclusive evidence that one approach is superior to another, time-restricted consultations and, perhaps, a feeling that people are not willing or able to maintain healthy lifestyle modifications.

In most of my consultations I try to talk about healthy living (this being recommended in the updated NICE guidance as something we should be offering at every stage in the treatment pathway), and carbohydrate awareness often forms a key part of my discussions. The notion of carbohydrate counting in type 2 diabetes is an interesting one and, as Hannah points out, it *can* be transformative for the right person – someone who is motivated, numerate, cognitively able and supported – but "a waste of everyone's time – or worse – for those who are not suited to it". This serves as a sharp reminder that "good practice" in diabetes care is never one-size-fits-all. This is exactly the shift that is expected in the NHS 10-Year Plan, with Integrated Neighbourhood Teams pushing for care that is tailored, pragmatic and person-centred, rather than protocol-driven.

The vision, as I understand it, is for neighbourhood teams to bring GPs, pharmacists, nurses, social prescribers, mental health teams and community services into one local structure. Care plans for diabetes and obesity will be built around the whole person: not just HbA_{1c}, BMI or weight targets. Better coordination of lifestyle support, easier access to structured education, more consistent follow-up after GLP-1 receptor agonist therapy and reduced fragmentation between primary, community and specialist care are key objectives. So too is equity of care, with a call for services to be built around the populations with the most to gain, not just the easiest to engage.

After more than 30 years of working in primary care, I've witnessed quite a few changes in the way services are designed and delivered; there have been lots of name changes and structural reforms. There have been genuine improvements in clinical quality, safety and the range of services available, with stronger multidisciplinary teams and better long-term condition management. But these gains have come with heavier workloads, greater complexity, increased administrative load, higher expectations and workforce shortages. Despite all of this, I still love my job and enjoy the challenges it brings.

One of the greatest privileges in my career was the opportunity to extend my impact beyond my day-to-day clinical work by becoming part of the Primary Care Diabetes & Obesity Society Committee (and later as Editor-in-Chief of this journal). Over many years, collaborating with like-minded people who see diabetes and obesity care not as a set of guidelines but as a human challenge that demands empathy, curiosity and teamwork has been a joy. On that note, I encourage you to consider applying to join the committee to help shape the future of primary care for diabetes and obesity.

By formally responding to the proposed NICE indicator on semaglutide, the Society demonstrates its role in shaping national policy and advocating practical, equitable pathways that protect primary care capacity and reduce health inequalities. While semaglutide is an important, evidence-based therapy for people with cardiovascular disease, we argue that the proposed NICE indicator is unsuitable for the Quality and Outcomes Framework because it

Jane Diggle
Specialist Diabetes Nurse Practitioner, West Yorkshire

Citation: Diggle J (2026) Editorial: Incretin therapies: Suitable for people with type 1 diabetes? *Diabetes & Primary Care* **28**: 139–41

Read more online

Diabetes Distilled: Nutritional, functional and psychological considerations for incretin-based therapies

Pragmatic guidance to help people optimise benefits from incretin-based weight loss drugs.

Diabetes & Primary Care **28**: 175–7

Click here to access

would create confusion, widen inequalities and place unsustainable pressure on primary care. Instead, we argue that commissioning should sit with Integrated Care Boards, supported by clear pathways, appropriate coding and wider consultation with professional bodies.

Incretin therapies for obesity and type 2 diabetes management

It is becoming genuinely difficult for clinicians to stay on top of the sheer volume, speed and complexity of new diabetes and obesity drugs. Meanwhile, public enthusiasm, fuelled by media coverage, private clinics and social media, creates demand that far exceeds NHS capacity to deliver. Public expectation needs to be carefully managed through honest messaging about eligibility, safety and the need for structured follow-up.

A new European consensus, reviewed in *Diabetes Distilled*, highlights that incretin therapies demand far more than dose titration alone; they require structured nutritional, functional and psychological support to ensure safe, effective and sustainable weight loss. As Pam Brown notes, medical nutrition therapy aims to improve gastrointestinal tolerance and drug adherence and support preservation of fat-free mass, underscoring the need for multidisciplinary care at a time when most people in the UK receive these drugs with highly variable wraparound support. The consensus offers practical dietary and nutritional strategies to preserve lean mass and minimise incretin side-effects. It is well worth a look!

Incretin-based therapies are being developed at great pace, including agents that act on more than just GLP-1. Amylin is a naturally occurring hormone that is released from the pancreas at the same time as insulin and plays a role in post-meal glucose regulation and appetite control. In the REIMAGINE series of trials, combining cagrilintide, an amylin agonist, with the GLP-1 RA semaglutide as a single weekly injection – CagriSema – was shown to produce greater HbA_{1c} reductions and more substantial weight loss than either drug alone in people with type 2 diabetes, as Pam Brown discusses here.

What about type 1 diabetes?

There is a rising prevalence of overweight and obesity in people with type 1 diabetes, a phenomenon sometimes described as "double diabetes", in which insulin resistance and metabolic syndrome coexist with autoimmune diabetes. As our At a glance factsheet discusses, real-world evidence suggests that tirzepatide can deliver substantial weight loss, lower insulin requirements and improve glycaemic variability in this population. However, at the PCDO Society we are increasingly being asked whether tirzepatide is licensed for use in this population. For the weight management indication, the licence and Summary of Product Characteristics do not specify type 1 diabetes as a contraindication. However, people with type 1 diabetes were excluded from the weight management clinical trials of tirzepatide, so we do not have clinical trial evidence of a positive benefit:risk balance in this population.

Thus, both the MHRA and the manufacturer have confirmed to us that use of tirzepatide for weight management in people with type 1 diabetes would be considered outside of the licence. This is also the case with other incretin therapies that were originally developed as type 2 diabetes treatments but now have additional uses in weight management. A joint statement from the PCDO Society and Association of British Clinical Diabetologists is expected soon to clarify these concerns.

Phase 2 and 3 clinical trials, including the manufacturer's SURPASS-T1D series, should help address this evidence gap in the future, and hopefully the results will align with the real-world findings so that people with type 1 diabetes can also benefit from use of these agents. However, the benefits come with important safety considerations. Slowed gastric emptying can cause post-meal hypoglycaemia, and rapid insulin reductions increase the risk of ketosis and diabetic ketoacidosis. For this reason, real-time CGM is recommended with cautious insulin adjustments.

The article stresses that for people with type 1 diabetes, tirzepatide should only be initiated within specialist diabetes or weight management services, whilst primary care's role should be to provide ongoing monitoring, safety-netting, and early escalation if concerns arise.

Also in this issue

Nicola Milne updates her How-to guide on initiating and supporting continuous glucose monitoring with a structured overview of

the technology, its benefits, limitations and eligibility criteria across UK nations, and practical steps for implementation in primary care reflecting recent changes, particularly new rules on driving. Related to this, in case you missed it, last issue I updated our guide to assessing fitness to drive, and I have also recorded a short podcast with David Miller on the topic, which I hope is of interest. It will be available here soon.

Adult obesity in the UK is rising but so too is childhood obesity. The implications of this for the future are profound, given it is such a strong predictor of adult obesity, early-onset type 2 diabetes, metabolic dysfunction-associated steatotic liver disease and obstructive sleep apnoea, as well as decreased quality of life. In *Diabetes Distilled* we review this Danish study, in which childhood overweight and obesity were strongly associated with lower birth rates in adulthood, particularly between ages 25 and 45. Notably, childhood BMI did not predict infertility diagnoses, which suggests that early-life weight may influence reproductive outcomes through mechanisms other than clinically recognised infertility. By remaining alert to opportunities to identify children with overweight or obesity, and by approaching families with sensitivity, we can play a vital role in early recognition, supportive conversations and timely referral.

SGLT2 inhibitors sit firmly within first-line therapy for most people with type 2 diabetes, supporting glycaemic control, weight loss and cardiorenal protection. Although diabetic ketoacidosis (DKA) associated with SGLT2 inhibitors is rare, it is serious and potentially life-threatening. It is vital that we highlight this risk when initiating or reviewing therapy, ensuring individuals understand sick-day rules, ketone awareness and, importantly, when to pause treatment and seek urgent medical advice. This brief report describes a case of euglycaemic DKA in a woman taking an SGLT2 inhibitor, outlining the circumstances that heighten DKA risk, along with the practical steps needed to prevent this serious complication.

As our confidence navigating the updated NICE NG28 guideline grows, you may also like to work through David Morris's latest interactive case study focusing on add-on medications for type 2 diabetes. Part 1, detailing the first-line medications, was published in the previous issue.

Meeting reports

The 2026 London Conference of the PCDO Society took place on Wednesday 1 July at the Royal College of GPs. Pam Brown has been hard at work noting down the key take-home points from the conference. This issue, she summarises sessions exploring the menopause, mental health, disordered eating and trauma, and separately, multimorbidity and frailty.

A little further from home, the 2026 International Congress on Obesity was held in Mexico City on 15–17 July. We also summarise the major talking points from the congress, including the consensus on nutritional, functional and psychological support discussed earlier, the benefits of GLP-1 RAs beyond weight loss, and the harms associated with so-called preclinical obesity and with ultra-processed food consumption.

Finally, as this long, hot and extremely dry summer is coming to an end, conference season will shortly be upon us again. Don't forget to book in for the excellent PCDO Society events, including conferences in Belfast, Glasgow and Birmingham. You can view them all here. I look forward to seeing you!

Diabetes & Primary Care

Volume 28 | Issue 4

Click to view the full table of contents