The 2026 ADA Standards of Care: What's new?

The American Diabetes Association (ADA) *Standards of Care in Diabetes* are "living guidelines" and are updated throughout the year as significant new evidence becomes available, with a full update published each January. This At a glance factsheet highlights key changes published in January 2026. Although some sections of the Standards reflect US practice, diabetes care is becoming more globally unified, so most recommendations are relevant to healthcare professionals in the UK. The changes highlighted here focus on those relevant to primary and community care teams. View the full guidance here.

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Section 2: Diagnosis and classification

- Offer autoantibody-based screening for presymptomatic type 1 diabetes (IA, GAD, IA-2 or ZnT8) to people with a family history of type 1 diabetes or otherwise known high genetic risk.
  - ➤ If positive for one or more islet autoantibodies, individuals should be evaluated for stage 3 (overt) type 1 diabetes (using urinalysis and/or plasma glucose testing).
  - ➤ Individuals with multiple confirmed islet autoantibodies but without overt type 1 diabetes should be referred to specialist care for presymptomatic type 1 diabetes staging, education and, potentially, preventative treatment (e.g. teplizumab).

Section 3. Prevention or delay of diabetes and associated comorbidities

- Mediterranean and low-carbohydrate diets are specified as having the best evidence for preventing or delaying onset of type 2 diabetes in high-risk individuals.
- **Cancer treatment:** Metformin should be considered to prevent hyperglycaemia in high-risk individuals treated with a PI3K alpha inhibitor (e.g. alpelisib, inavolisib) for cancer or high-dose glucocorticoids.

4. Comprehensive medical evaluation and assessment of comorbidities

- In people with type 2 diabetes, (MASLD) and obesity/overweight, consider a GLP-1 RA with demonstrated benefit for MASH.
  - ➤ These GLP-1RAs are also preferred for glucose-lowering in those with type 2 diabetes and biopsy-proven MASH or high risk of liver fibrosis.

Section 5. Facilitating positive health behaviours

- Lifestyle plans involving diet, physical activity and other health behaviours should aim for a weight loss target of 5–7% of baseline body weight (a more aggressive target than in previous Standards).
- Screening for anxiety, and for fear of hypoglycaemia in those at risk of or having recurrent hypoglycaemia, is recommended at least annually in people with diabetes.

New and updated figures and algorithms

- Individualised HbA_{1c} and CGM goals depending on individual age, health and function – view here
- Insulin management in type 1 diabetes – view here
- Prevention and treatment of symptomatic heart failure in people with diabetes – view here
- Approach to preventing atherosclerotic cardiovascular disease in people with type 2 diabetes – view here
- Stepwise framework for diabetes treatment for older people, including deintensifying treatment – view here

  - ➤ Referral to a behavioural therapist should be considered if diabetes distress is not adequately dealt with in the consultation.
  - ➤ Repeat screening when treatment goals are not met, at transitional times and/or in the presence of diabetes complications should be considered.

Section 6. Glycaemic goals, hypoglycaemia and hyperglycaemic crises

- An updated figure suggests individualised glycaemic targets for both HbA_{1c} and CGM metrics, based on age, frailty and health status.

Section 7. Diabetes technology

- As expected, this section has been extensively updated. CGM, insulin pumps and automated insulin delivery should be considered early in diabetes, including at diagnosis. The updated advice specifies that there should be no requirement of C-peptide level, presence of islet autoantibodies or duration of insulin treatment before initiation of insulin pumps or automated systems.

Section 8. Obesity and weight management for the prevention and treatment of diabetes

- Screen annually for overweight and obesity using BMI **and** another method to confirm excess adiposity.

- In those with overweight or obesity, weight loss of 5–7% is supported by the evidence base to improve glycemia and other intermediate cardiovascular risk factors.
- Individuals pursuing intentional weight loss should be advised to ensure adequate nutritional intake, with particular attention to preventing protein insufficiency and micronutrient deficiencies.
- The dose and titration of obesity pharmacotherapy should be individualised to balance effectiveness, health benefits and tolerability. The guidance notes that the optimal treatment dose may not be the maximum approved dose.
- A new subsection on treatment of obesity in type 1 diabetes has been added. GLP-1 RA-based therapy and/or metabolic surgery are included as treatment options for obesity in people with type 1 diabetes.

Section 9. Pharmacological approaches to glycaemic treatment

- GIP/GLP-1 RAs and GLP-1 RAs with evidence of heart failure benefit have been added to the list of medications recommended for people with type 2 diabetes, obesity and symptomatic heart failure with preserved ejection fraction, irrespective of HbA_{1c}.
- GLP-1 RAs can now be considered in those with type 2 diabetes and chronic kidney disease.
- Certain GLP-1 RAs now have demonstrated benefits in MASH, and are recommended alongside pioglitazone or GIP/GLP-1 RAs in people with type 2 diabetes and biopsy-proven MASH or those at high risk for liver fibrosis.
- Use of CGM is now recommended at diabetes onset and any time thereafter for adults who are on insulin, oral therapies that can cause hypoglycaemia and any diabetes treatment where CGM aids in management.
- Automated insulin delivery systems should be offered to all adults with type 2 diabetes on insulin therapy, as well as those with type 1 diabetes.
- New recommendations for glycaemic management in the context of cancer treatment:
  - Individuals who develop hyperglycaemia during treatment with immunotherapy may require immediate initiation of insulin therapy (to prevent diabetic ketoacidosis) while additional testing is completed to determine if the hyperglycaemia is related to immunotherapy-associated diabetes.
  - Metformin is recommended first-line to treat hyperglycaemia due to mTOR inhibitors or PI3K alpha inhibitors. Due to its potential impact on the efficacy of PI3K inhibitors, insulin should be reserved for treatment of severe hyperglycaemia and hyperglycaemic crisis.
  - For individuals undergoing glucocorticoid treatment, adjust or initiate additional glucose-lowering therapies to maintain individualised glycaemic targets based on the specific glucocorticoid treatment plan.
- A new algorithm on insulin management in type 1 diabetes has been added. Figure 9.4 has been updated to include GIP/GLP-1 RAs for people with type 2 diabetes, symptomatic HFpEF, MASLD or MASH, and obesity.

Section 10. Cardiovascular disease and risk management

- A systolic blood pressure target of <120 mmHg is now recommended for people with high cardiovascular or renal risk.
- ACEi or ARB strongly recommended to treat hypertension if severely increased albuminuria or confirmed chronic kidney disease; titrate to highest tolerated dose to reduce renal and cardiovascular events.
- In individuals on statin therapy, the addition of fibrate, niacin or dietary supplements containing n-3 fatty acids is not recommended, as they do not provide additional cardiovascular risk reduction.
- GLP-1 RAs with demonstrated benefits are recommended for people with chronic kidney disease and asymptomatic (stage B) heart failure with high risk of or established cardiovascular disease.
- GIP/GLP-1 RAs and GLP-1 RAs with demonstrated benefits have been added to the list of medications recommended for HFpEF.
- A non-steroidal MRA with proven benefit is now recommended in individuals with diabetes and symptomatic stage C heart failure with ejection fraction >40%.
- New figures:
  - Recommendations for the prevention and treatment of symptomatic heart failure in people with diabetes.
  - Approach to preventing atherosclerotic cardiovascular disease in people with type 2 diabetes.

Section 11. Chronic kidney disease and risk management

- In addition to a RAS blocker, simultaneous initiation of an SGLT2 inhibitor and a non-steroidal MRA can be considered in adults with type 2 diabetes and uACR ≥100 mg/g (~11 mg/mmol) with eGFR 30–90 mL/min/1.73 m^2.

Section 13. Older adults

- Specific blood pressure treatment targets are now proposed: <130/80 mmHg (if achievable safely) for most older adults, and <140/90 mmHg for those with poor health, limited life expectancy or high risk of adverse effects with hypertensive therapy.
- Specific protein intake is recommended for older adults with diabetes:
  - At least 0.8 g/kg body weight/day to maintain lean body mass and function. Potentially higher, individualized amounts if lean body mass and function need to be regained.
- Specific guidance on assessing geriatric syndromes and other functional impairments using sample screening questions and validated languages has been added.
- New stepwise framework for diabetes treatment for older people, including deintensifying and simplifying treatment. ■