New roles and resources for incretin therapies

The DVLA's guidance was updated in November 2025, with significant changes to glucose monitoring rules for Group 2 drivers. Navigating the guidance on diabetes and driving is not straightforward, and I attended a session on this very topic, presented by Professor Pratik Choudhary, at the recent Diabetes UK Professional Conference. When the audience was presented with a series of multiple-choice questions, there was marked variation in the answers selected, which illustrates that, even in a group of healthcare professionals with a specialist interest in diabetes, there is lack of clarity and even some interpretive ambiguity.

Clinicians have a clear professional responsibility to inform their patients with diabetes exactly when they need to notify the DVLA and what monitoring is required before and during driving. I hope that my fully updated *How to* provides a practical reference for day-to-day clinical use.

Sharing examples of good clinical practice enables colleagues to learn from one another, reduces unwarranted variation and promotes a consistent, evidence-based approach. I would like to introduce a new feature in the journal which does just that, *Sharing Innovation in Clinical Practice*, with the first in the series describing how a group in Leeds developed educational resources to improve understanding, confidence and uptake of injectable therapies such as PCSK9 inhibitors and GLP-1 receptor agonists. These were developed to address some of the common barriers and to support better cardiovascular care.

New roles and resources for incretin therapies

Much of this issue of the journal focuses on drug treatments, reinforcing the growing complexity, the expanding therapeutic choices and the rapid pace at which new evidence continues to reshape clinical practice. There continues to be significant interest in GLP-1 RAs and tirzepatide among clinicians and the public alike, reflecting their growing role across cardio–renal–metabolic care.

Interestingly, from 2026–27, new Quality and Outcomes Framework (QOF) indicators have been introduced that incentivise practices to refer to weight management services and engage in shared decision-making and medicines optimisation for obesity (NHS England, 2026). At this stage, I'm not clear how we are going to do this, given that access to weight management services across the UK remains highly inconsistent, owing to fragmented commissioning and variable local funding and provision of specialist services. Eligibility for evidence-based interventions, including GLP-1 and GIP/GLP-1 RAs, depends heavily on geography rather than clinical need, reinforcing a persistent postcode lottery in care.

Implementation will depend on appropriate funding and the sheer scale of demand. However these therapies are implemented, what remains essential is the incorporation of appropriate wraparound care to ensure safe, effective and sustainable weight management. In their commentary, Clare Hambling and colleagues from NHS England describe the wraparound care required when prescribing tirzepatide for weight management in primary care, explaining how clinical and behavioural components work together within an emerging, holistic obesity pathway, supported by the QOF obesity indicators and a new national behavioural support service to ensure safe, equitable and person centred care.

Within general practice, we have developed substantial expertise in prescribing incretin-based therapies for diabetes, and this skillset is readily transferable to their use in weight management. Our latest *Prescribing pearl* clarifies the licensed indications for injectable semaglutide and tirzepatide, and their current positioning in NICE guidance for weight management. It provides a useful summary of dosing, adverse effect profiles, drug interaction considerations and key counselling points to support safe, effective prescribing in clinical practice.

The updated NICE NG28 guideline marks a significant shift in management of atherosclerotic

Jane Diggle
Specialist Diabetes Nurse Practitioner, West Yorkshire

Citation: Diggle J (2026) Editorial: New roles and resources for incretin therapies. *Diabetes & Primary Care* **28**: 45–8

Read more online

The NICE NG28 type 2 diabetes guideline: Management update – what's new?

A complete overhaul to the medicines algorithm recommends metformin M/R and SGLT2 inhibitors for the majority of people.

Diabetes & Primary Care **28**: 5–8

Click here to access

cardiovascular disease (ASCVD) by recommending subcutaneous semaglutide (up to 1 mg) for people with type 2 diabetes and established ASCVD, recognising its proven cardiovascular risk reduction benefits (NICE, 2026a). NICE has also just published draft guidance recommending semaglutide (up to 2.4 mg) for individuals without type 2 diabetes who have ASCVD and a BMI of 27 kg/m^2 and above (NICE, 2026b). The recommendation was based largely on evidence from the SELECT trial, which demonstrated a clinically meaningful reduction in major cardiovascular events in people without diabetes, reducing the composite risk of cardiovascular death, non-fatal myocardial infarction and non-fatal stroke by 20% (Lincoff et al, 2023).

This represents a major shift in UK practice because it reframes semaglutide not only as a diabetes and/or weight loss therapy, but also as a cardioprotective agent for high-risk patients. Integrated Care Boards will be expected to fund the drug within 90 days of the final published guidance, expected in May 2026. I suspect much of the responsibility for initiating and managing these agents will fall to GPs, making it essential that we continue to strengthen our skills and confidence in this area.

Pausing versus stopping medications

A question I am not infrequently asked is whether a person needs to pause certain diabetes medications ahead of surgery or other procedures, in particular gastrointestinal investigations. The MHRA (2025) has formally warned that GLP-1 RAs and tirzepatide can increase the risk of pulmonary aspiration during general anaesthesia or deep sedation because they delay gastric emptying, leading to residual gastric contents even after standard fasting. It did not mandate a universal "stop before surgery" rule because evidence was insufficient to set a specific withholding interval, but it did emphasise that anaesthetists should explicitly ask patients whether they are taking incretin therapies, including via private prescription for weight loss, and to undertake an individualised perioperative risk assessment.

In *Diabetes Distilled*, Pam Brown summarises findings from the OCULUS trial, which investigated whether continuing versus withholding GLP-1 or GIP/GLP-1 RAs before upper gastrointestinal endoscopy affected the risk of clinically significant residual gastric volume. What I found interesting was that withholding one dose of the drugs prior to the procedure reduced the risk but did not wholly eliminate it, whereas restricting to clear fluids for 24 hours prior to the procedure did appear to do so.

There is often debate as to whether these agents, and others, including SGLT2 inhibitors, should be paused ahead of elective surgery. Clearly, with SGLT2 inhibitors, there are concerns around the increased risk of diabetic ketoacidosis, but optimum glycaemic control is important too, creating something of a prescribing dilemma. I would highly recommend the multidisciplinary consensus statement referenced in Pam's article to learn more on this issue (El Boghdadly et al, 2025).

Reducing treatment burden, increasing adherence

There is always a worry that when we ask people to pause a medication for a period of time they actually stop it permanently, which leads me to the issue of adherence. It was World Adherence Day on 27 March 2026, and Pankaj Gupta and colleagues highlight how common medication non-adherence (often hidden) is in type 2 diabetes, yet it remains underdiscussed in routine care, despite being strongly associated with worse outcomes. The article offers a practical, person-centred, three-step approach – Ask, Check, Chat – to normalise these conversations, identify non-adherence using objective methods, and address underlying barriers through supportive, non-judgemental dialogue.

Non-adherence is more likely in people who are prescribed multiple medications. Furthermore, when people take multiple medications, as is often the case with type 2 diabetes, the side-effects of one drug can easily be mistaken for a new medical condition, leading to another drug being added to treat the symptoms caused by the first. Over time, this "prescribing cascade" increases treatment burden, raises the risk of harm, and can leave the original problem unrecognised. Lisa Devine's

illustrative case report highlights how easily these prescribing cascades develop and reminds us of the importance of pharmacovigilance, structured medication review, and deprescribing strategies to prevent harm and reduce treatment burden.

For people who are anxious about injections, oral GLP-1 RAs offer a valuable alternative, providing the benefits of incretin therapy without the need to inject. Oral semaglutide (Rybelsus®) can be an excellent option for people who prefer to avoid injections, but it does require very precise dosing conditions because its absorption is highly sensitive to timing, stomach contents and coadministered medications. Orforglipron is a small-molecule, non-peptide GLP-1 RA that can be taken orally without any special precautions in relation to food or drink, unlike oral semaglutide, which requires fasting and strict administration rules. Orforglipron is currently not licensed in the UK, although regulatory submissions are underway, and it may offer some advantages for those who would struggle to adhere to the strict dosing requirements of oral semaglutide. It is encouraging, therefore, to see positive findings from the phase 3 ACHIEVE-3 trial, which compared once-daily orforglipron (12 mg and 36 mg) with oral semaglutide (7 mg and 14 mg) in adults with type 2 diabetes. Pam Brown reviews the findings.

When discussing the pros and cons of GLP-1 RAs and tirzepatide, I am often asked how much weight loss a person is likely to achieve, by how much their HbA_{1c} will lower and whether they will experience side-effects. We can share data from published studies, which I do, particularly as many people have trawled the internet and social media and their expectations are exaggerated and often unrealistic. However, in practice it is impossible to predict how well a person will respond to these therapies. Or is it? Increasingly, we are hearing the term "precision medicine", an approach that tailors medical treatment to the individual characteristics of each person, rather than adopting a one-size-fits-all approach. I'm sure this is what we all try to do, but precision medicine takes this a step further to include information about a person's genes, environment and lifestyle to guide treatment decisions. I was drawn to a short comment piece in the *BMJ* a couple of weeks ago discussing how scientists have identified genetic variants associated with slightly greater weight loss and side-effect incidence in people taking GLP-1 RAs (Wise, 2026). This helps to explain the variable response we see in practice, and in the future this might be used to inform treatment decisions. However, I still strongly believe we cannot underestimate the positive impact of simultaneous healthy lifestyle changes.

Equally, emotional wellbeing has a profound influence on a person's ability to self-manage their diabetes, shaping motivation, confidence, decision-making and day-to-day engagement with treatment and healthy living. Mental health problems are very common in people living with diabetes – far more common than in the general population – and David Morris explores how we can help in his latest interactive case study.

Finally, a common question I get asked is whether a person should stop their GLP-1 RA or tirzepatide, especially when they have achieved their HbA_{1c} and/or weight targets. When prescribing for type 2 diabetes, provided the drug is tolerated and there are no safety concerns (e.g. suspected pancreatitis, worsening retinopathy, pregnancy or planning pregnancy, clinically concerning excessive weight loss), I would rarely suggest stopping. However, for those purchasing these agents privately for weight loss, the cost implications may preclude long-term use.

The question of weight regain on stopping these drugs is, thus, an important message to convey, but one I suspect is not routinely shared. In *Diabetes Distilled*, Pam discusses the findings and practical implications of a *BMJ* systematic review and meta-analysis of people stopping weight loss medications. I was interested to learn that people regain weight far more quickly than previously assumed, with an average of 0.4 kg per month gained after cessation of any weight management medication and a full return to baseline weight after an estimated average of 1.7 years. Regain is even faster after stopping semaglutide or tirzepatide, at 0.8 kg per month and with a return to baseline weight by 1.5 years. People need to understand from the outset that weight regain is likely once weight loss medications are

Read more online

Prescribing pearls: Semaglutide and tirzepatide for weight management

Indications, effects and prescribing tips for the injectable incretin therapies licensed for weight management.

Diabetes & Primary Care **28**: 53–5

Click here to access

Diabetes & Primary Care

Volume 28 | Issue 2

Click to view the full table of contents

stopped, so that this expectation can be built into informed decision-making.

I shall be co-presenting a masterclass on the common questions and queries around GLP-1 RA prescribing at the PCDO Society National Conference in November. I am in the process of gathering the most commonly asked questions, but I would be grateful if you could send yours in, anonymously, by filling in this form.

Finally, a reminder that entries are now open for the poster competition at the National Conference. Posters should provide examples of good practice or innovation in diabetes or obesity care within the primary care setting, highlighting work that is of relevance and, ideally, practical significance to other primary care teams. Accepted posters will be displayed in the exhibition hall during the conference and will be judged by the PCDO Society Committee. An award will be presented for the entry that reflects the best contribution to diabetes and obesity within the primary care setting.

Entries are also open for the Roger Gadsby Award recognising an outstanding audit in primary care diabetes or weight management, with a cash prize of £500 for the winner. You can learn more here, and please do submit your entries by 28 August. ■

El-Boghdadly K, Dhesi J, Fabb P et al (2025) Elective peri-operative management of adults taking glucagon-like peptide-1 receptor agonists, glucose-dependent insulinotropic peptide agonists and sodium–glucose cotransporter-2 inhibitors: A multidisciplinary consensus statement. *Anaesthesia* **80**: 412–24

Lincoff AM, Brown-Frandsen K, Colhoun HM et al; SELECT trial investigators (2023) Semaglutide and cardiovascular outcomes in obesity without diabetes. *N Engl J Med* **389**: 2221–32

MHRA (2025) *GLP-1 and dual GIP/GLP-1 receptor agonists: Potential risk of pulmonary aspiration during general anaesthesia or deep sedation*. Available at: https://bit.ly/4cSJjCk

NHS England (2026) *Quality and Outcomes Framework Guidance for 2026/27 – Section 4.4 Obesity (OB)*. Available at: https://bit.ly/42uLsOv

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

NICE (2026b) *Semaglutide for reducing the risk of major adverse cardiovascular events in people with cardiovascular disease and overweight or obesity* [ID6441]. Available at: https://www.nice.org.uk/guidance/indevelopment/gid-ta11544

Wise J (2026) Genetic variants show link to patients losing more weight when taking Wegovy and Mounjaro. *BMJ* **393**: s693