

New guidelines,
new opportunities

Leonardo Hotel, Cardiff | 7 May 2026

17TH Welsh
Conference

PCDO
Society



Diabetes distilled Pam Brown

GP with an interest in diabetes, obesity and lifestyle medicine
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Development lead, Obesity and weight management MSc

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My disclosures

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Janssen, MSD, Napp and Novo Nordisk,

OmniaMed, RCGP, Innovate, Sherborne Gibbs

Thank you to Professor Steve Bain, Jane Diggle and colleagues and friends for ideas and inspiration. Any errors are my own.



Diabetes distilled - an e-newsletter from the Primary Care Diabetes and Obesity Society - shares the latest developments in diabetes and obesity for primary care and community teams.

Sign up to receive the Diabetes Distilled newsletter at the link below



How many of you see Diabetes Distilled regularly?



Diabetes Distilled: Incretin therapies and endoscopy safety

Risk of residual gastric volume seen in people taking injectable incretin agents prior to endoscopy.

20 Apr 2026



Diabetes Distilled: Greater reductions in HbA1c ACHIEVED with orforglipron versus oral semaglutide 14 mg

Greater efficacy at the cost of more adverse events in this developmental oral GLP-1 receptor agonist.

2 Apr 2026



Diabetes Distilled: Weight regain after stopping newer weight management drugs is faster than anticipated

Weight returns to baseline levels an estimated 1.5 years after stopping semaglutide or tirzepatide.

23 Mar 2026



Diabetes Distilled: SUPAS-CVOT - Tirzepatid demonstrates cardiovascular benefit in secondary prevention

3-point MACE occurred in 12.2% vs 13.1% of tirzepatide and dulaglutide recipients, respectively, confirming non-inferiority.

6 Mar 2026



Diabetes Distilled: Shared decision-making can improve obesity care in people with type 2 diabetes

Why is shared decision-making important, what barriers are there and what tools can support it?

6 Mar 2026



Diabetes Distilled: Statins effective for primary cardiovascular prevention at all risk levels in type 2 diabetes

Findings should motivate us to encourage statin initiation and persistence for primary prevention in more people with type 2 diabetes.

6 Mar 2026

What do we need, to implement NICE NG28 changes?

- ✓ Triage people to 7 tracks
 - ✓ Shared decision-making if fit more than one track
 - Deliver lifestyle advice; support adherence
- Confidence initiating SGLT2 inhibitors and GLP-1 RAs/tirzepatide

Where will the time and resources come from?
Have we discussed implementation with our team?

At a glance factsheet: The NICE NG28 type 2 diabetes guideline



<https://diabetesonthenet.com/diabetes-primary-care/factsheet-nice-ng28-feb-2026/>

Diabetes & Primary Care

The journal for healthcare professionals with an interest in primary care diabetes



This issue:

The updated NICE type 2 diabetes guideline

Prescribing SGLT2 inhibitors safely and effectively

3 important goals/actions for both drug classes

- ✓ Are they contraindicated?
- ✓ What are the special precautions in this person?
- ✓ What counselling is needed to increase safety?

Would a checklist be helpful?

Prescribing pearls: A guide to SGLT2 inhibitors

How to use SGLT2 inhibitors safely and effectively

The guidance on when to use is being updated to match NG28; other safety information helpful

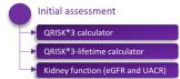
SGLT2 Inhibitors – The New Standard of Care for Cardiovascular, Renal and Metabolic Protection in Type 2 Diabetes: A Narrative Review

Diabetes Ther (2024) 15:1099–1124

1111

Key practice points:

- Discuss the relative benefits and risks of SGLT2 therapy with the person you are treating.
- Use dual first-line SGLT2 therapy with metformin (unless contraindicated); initiate 4 weeks after metformin, post-date the SGLT2i prescription and do not wait for HbA1c assessment of 3 months after metformin initiation.
- Emphasise the importance of ongoing hydration and good personal hygiene.
- Give written information/electronic resources to support advice on the management of T2DM medicines during periods of acute or dehydrating illness.
- If symptomatic of hyperglycaemia, start rescue therapy and then reassess initiation of SGLT2i when symptoms resolved.
- For planned surgery or procedures requiring nil by mouth, advise on the importance of pausing SGLT2i treatment 3–7 days prior to surgery or those with pre-operative team.
- Please refer to the relevant SmcC before prescribing any SGLT2i therapy.
- Discussion with an expert clinician is advisable for more complex cases.



Frailty/older people/cognitive impairment
 Ketogenic/very low calorie/low carbohydrate diet
 BMI <25 kg/m² (adjust according to ethnic variation)
 Recurrent genital mycotic infections and UTIs
 Symptomatic hyperglycaemia
 History of PAD and/or lower limb amputation (discuss with local specialist foot team)
 QRISK*3 (where available or QRISK*2) <10%



Acute illness with risk of dehydration
 Current or previous diabetic ketoacidosis
 Low beta-cell function (low C-peptide levels)
 Rapid progression to insulin (within 1 year)
 Excessive alcohol intake
 Suspected LADA or slowly evolving immune-related diabetes
 Chronic pancreatitis and/or PEI
 Type 3c diabetes
 Suspected pancreatic cancer
 Pregnancy/suspected pregnancy, planning pregnancy or breastfeeding
 Planned surgery or procedure requiring starvation/nil by mouth (3–7 days prior to planned surgery)
 Type 1 diabetes
 Unclear diagnosis of diabetes

IMPORTANT – this decision tool is for guidance only. The final clinical decisions are the responsibility of the prescriber.

First-line combination therapy with metformin* or monotherapy if metformin is contraindicated or not tolerated in people with one of the following:
 • QRISK*3 (where available or QRISK*2) >10%
 • HF
 • Established ASCVD
 • CKD/ODK
 *If using with metformin, initiate metformin first and titrate over a 4-week period, and then start SGLT2i therapy
Combination therapy with either oral glucose-lowering therapy in people with:
 • QRISK*3 (where available or QRISK*2) >10%
 • CVD
 • HF
 • CKD
 Young onset T2DM (aged 18–40 years), unless planning pregnancy
 Overweight or obesity in the absence of GLP-1 RA
 Vulnerable to the effects of hypoglycaemia

- ✓ Initiate drugs sequentially
- ✓ Initiate/continue down to eGFR 20ml/min/1.73m²
- ✓ eGFR <45 ml/min/1.73m² - minimal or no glucose lowering but cardio-renal benefits continue
- ✓ Those in socioeconomically challenged groups get more benefit
- ✓ Check not on ketogenic diet or other risk factors for DKA
- ✓ Share sick day rules and remind to pause for surgery

Ensure we are confident of the contraindications and special precautions
 Practice discussing side effects and sick day rules – document in record

SGLT2 inhibitors - What's new?

- ✓ Higher DKA risk if baseline HbA1c >8.3% (67mmol/mol)
 - ✓ 15 observational studies 7 RCTs
 - ✓ Caution but not C/I initiation >67mmol/mols
 - ✓ Educate carefully
- Seidu et al Diab Obes Metab 2026

- ✓ Almost double phimosis risk in uncircumcised men using SGLT2is v GLP-1RAs
 - ✓ Need for increased genital hygiene guidance
- Ljungberg et al Diabetes Care 2025; 48:1774-1782

Risk factors for DKA include:

- Low beta-cell function (e.g. those with T2DM and low C-peptide levels, LADA/slowly evolving immune-related diabetes or a history of pancreatitis). Ensure correct diagnosis of T2DM before initiating SGLT2i treatment.
- Restricted food intake (very low calorie or very low carbohydrate diet) or severe dehydration [see **BOX E** for advice on intermittent fasting].
- Sudden reduction in insulin.
- Increased insulin requirements due to rising glucose levels (e.g. during acute illness).
- Surgery or surgical procedure that requires fasting.
- Alcohol abuse.
- Corticosteroid use.

- ✓ How can we reduce the risk of DKA?
- ✓ How can we increase early detection if it occurs?
 - ✓ Do all our team know about testing ketones?
- ✓ Would a checklist help?

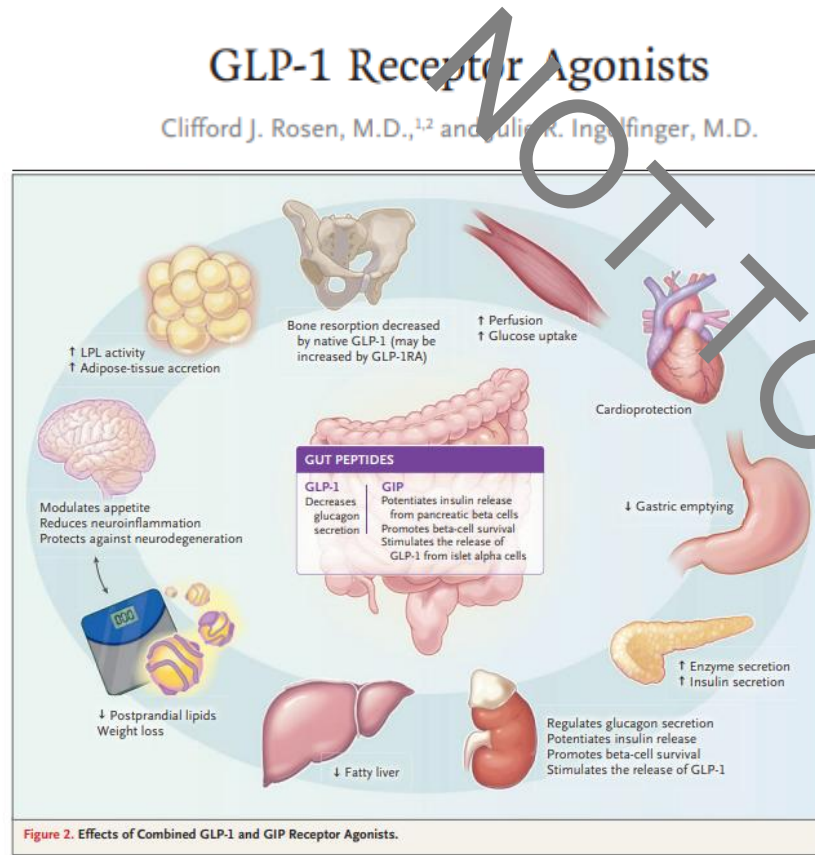
How to Advise on Sick Day Rules

Citation: Down S (2020) How to advise on sick day rules. *Diabetes & Primary Care* 22: 47–8

SADMAN guidance
SUs, SGLT2is, ACEI,
Diuretics, Metformin, ARBs,
NSAIDs

What's new in GLP-1 RAs/tirzepatide?

Prescribing pearls: Semaglutide and tirzepatide for weight management



Rosen and Ingelfinger NEJM 2026; 394:1313-24

- ✓ Adverse events prevalence increasing especially pancreatitis in Europe Hughes et al BJS 2026; 113
 - ✓ 1296 reports pancreatitis 2007-2025 MHRA Jan 2026
- ✓ Non-arteritic anterior ischaemic optic neuropathy (NAION) with semaglutide
 - ✓ Rare - painless usually unilateral permanent visual loss 11-82/100,000 person-yrs MHRA Feb 2026
- ✓ Short term increased risk compared to DPP4 inhibitors Noh et al Diabetes Care 2026; 49:763-771

Do we know who are using GLP-1 RAs/tirzepatide privately – is this coded?
Have we agreed whose responsibility it is to check for contraindications?
Build confidence in demonstrating devices and injection technique

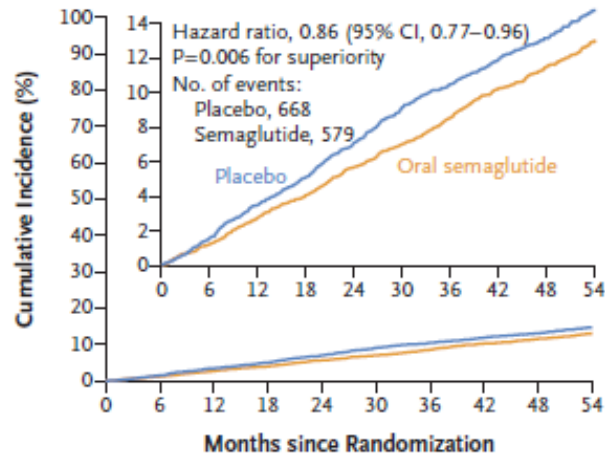
Cardiovascular outcome studies

NG 28 - offer semaglutide s.c. triple therapy

Oral Semaglutide and Cardiovascular Outcomes in High-Risk Type 2 Diabetes

N Engl J Med 2025;392:2001-2012

Major Adverse Cardiovascular Events

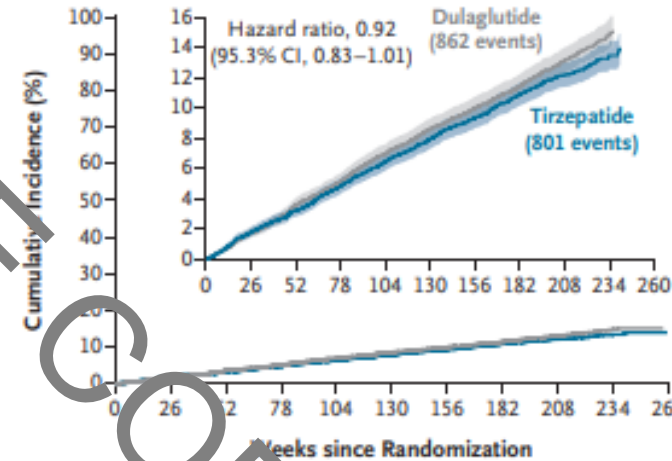


- ✓ 14% MACE reduction
- ✓ No CKD benefit unlike in FLOW

Cardiovascular Outcomes with Tirzepatide versus Dulaglutide in Type 2 Diabetes

N Engl J Med 2025;393:2409-20.

A Composite of Death from Cardiovascular Causes, Myocardial Infarction, or Stroke



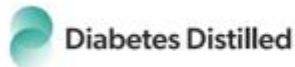
- ✓ Dulaglutide 1.5mg v tirzepatide to 15mg
- ✓ MACE non-inferior median 4yrs
- ✓ HbA1c + weight reduction higher with tirzepatide

REWIND study dulaglutide 12% MACE reduction

Gerstein et al Lancet 2019; 394: 121-30

SURPASS CVOT - Tirzepatide demonstrates cardiovascular benefit in secondary prevention

S.C semaglutide 0.5-1mg 26% reduction MACE



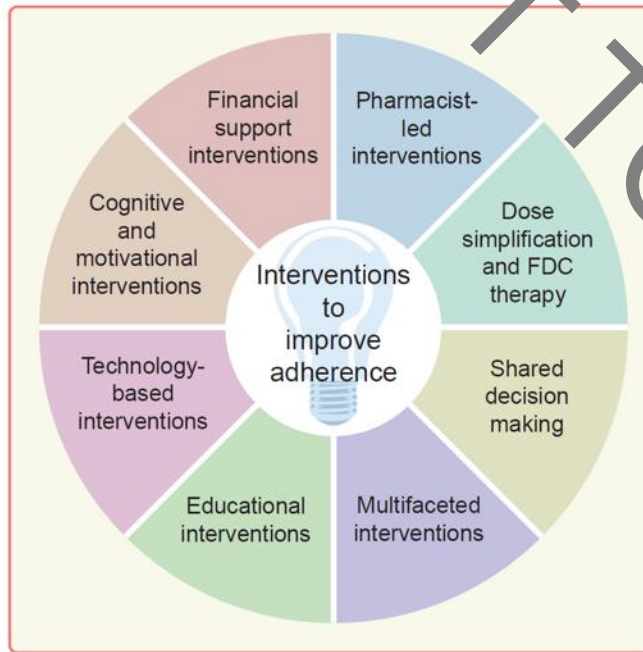
Heart and SOUL – oral semaglutide demonstrates cardiovascular benefit in high-risk people with type 2 diabetes

How many of people with T2DM and ASCVD are already on triple therapy?

Have we added semaglutide after new ASCVD event once stable on dual therapy?

How can we help with adherence?

Intervention strategies to improve medication adherence in type 2 diabetes



Highton et al (2025) Diabetologia DOI 10.1007/s00125-025-06617-x

Shared decision-making can improve obesity care in people with type 2 diabetes

Diabetes Distilled

Diabetes and primary care 28: 33-35

Benefits of fixed dose combination therapy in the treatment of type 2 diabetes

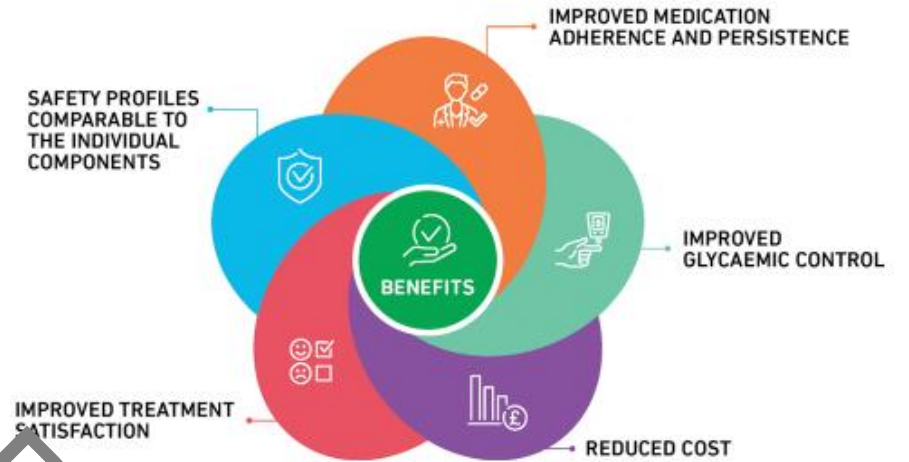
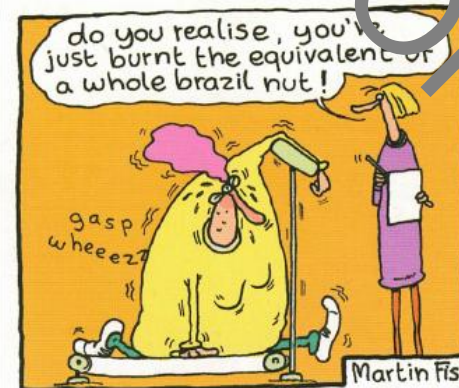
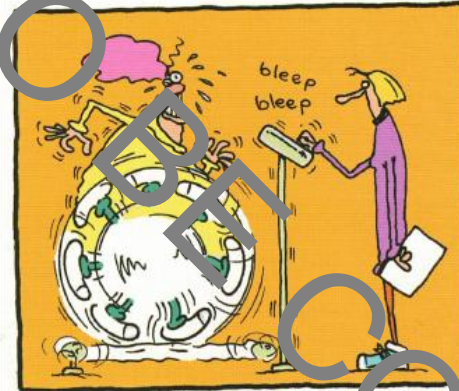
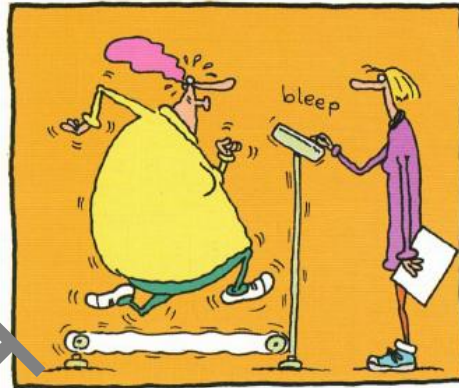


Fig. 1 Summary of the benefits of fixed-dose combination therapy in type 2 diabetes

Highton, Funnell, Khunti Diabetes Ther 2026

Do we explore adherence before escalating therapy?

‘Have you found problems with any of your medicines?’



What simple messages can we share about food?

Key Nutrition Principles:

Include

- Nonstarchy vegetables
- Lean proteins
- Whole grains
- Nuts and seeds
- Low-fat dairy products or nondairy alternatives
- Whole fruits
- Legumes



Minimize

- Red meat
- Sugar-sweetened beverages
- Sweets
- Refined grains
- Processed and ultraprocessed foods
- Adding salt as seasoning

- ✓ Talk about what people can ADD – more REAL FOODS
- ✓ Any beneficial change will help long term

ADA Standards of Care Abridged for primary care 2026
Diabetes Obes Cardiometab CARE 2026 Online

Dietary Guidance for Cardiovascular Health

Maintain a healthy body weight

CHOOSE

<p>Plenty of vegetables and fruits</p>	<p>Healthy proteins</p>	<p>Whole grains</p>	<p>Unsaturated fats</p>
MINIMIZE			
<p>Added sugars</p>	<p>Sodium</p>	<p>Ultraprocessed foods</p>	<p>Alcohol*</p>

*If you don't drink, don't start

copyright American Heart Association

Lichtenstein et al 2026 Circulation

Remember food insecurity and lack of cooking skills

10 TIPS FOR HEALTHY EATING WITH DIABETES

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Eat Real Food

Chris van Tulleken

Ultra-Processed People

Why Do We All Eat Stuff That Isn't Food... and Why Can't We Stop?

Food Intelligence

The science of how food both nourishes and harms us

Total Fat 1.5g
Saturated Fat 0.5g
Trans Fat 0g
Polyunsaturated Fat 0.5g
Monounsaturated Fat 0.5g

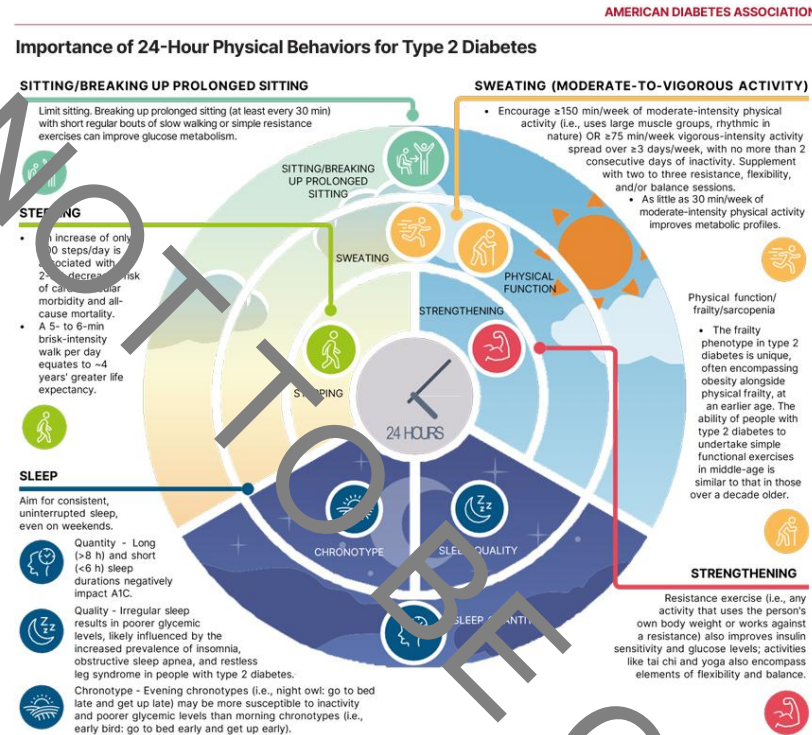
Julia Belluz & Dr Kevin Hall

Physical activity

- ✓ Walking for all*
- ✓ Do more than you are doing at present
- ✓ 'Weekend warrior' pattern OK
- * Care if neuropathy, retinopathy or ulcers

Exercise snacks reduce postprandial hyperglycaemia

Diabetologia Open access Online first 24.4.26



ADA Standards of Care 2026 - section 5

	Glucose/insulin	Blood pressure	A1C	Lipids	Physical function	Depression	Quality of life
SITTING/BREAKING UP PROLONGED SITTING	↓	↓	↓	↓	↑	↓	↑
STEPPING	↓	↓	↓	↓	↑	↓	↑
SWEATING (MODERATE-TO-VIGOROUS ACTIVITY)	↓	↓	↓	↓	↑	↓	↑
STRENGTHENING	↓	↓	↓	↓	↑	↓	↑
ADEQUATE SLEEP DURATION	↓	↓	↓	↓	?	↓	↑
GOOD SLEEP QUALITY	↓	↓	↓	↓	?	↓	↑
CHRONOTYPE/CONSISTENT TIMING	↓	?	↓	?	?	↓	?

IMPACT OF PHYSICAL BEHAVIORS ON CARDIOMETABOLIC HEALTH IN PEOPLE WITH TYPE 2 DIABETES

Sleep

- ✓ How well and how long do you sleep?
- ✓ Quantity – 7 hours 37 optimal
 - ✓ 7-9 hour range
- ✓ Quality – check for sleep apnoea
- ✓ Timing – consistent
- ✓ 1-2 hour catch up weekly OK only if genuine sleep deficit

Exercise pills for cardiometabolic health cannot mimic the exercise milieu

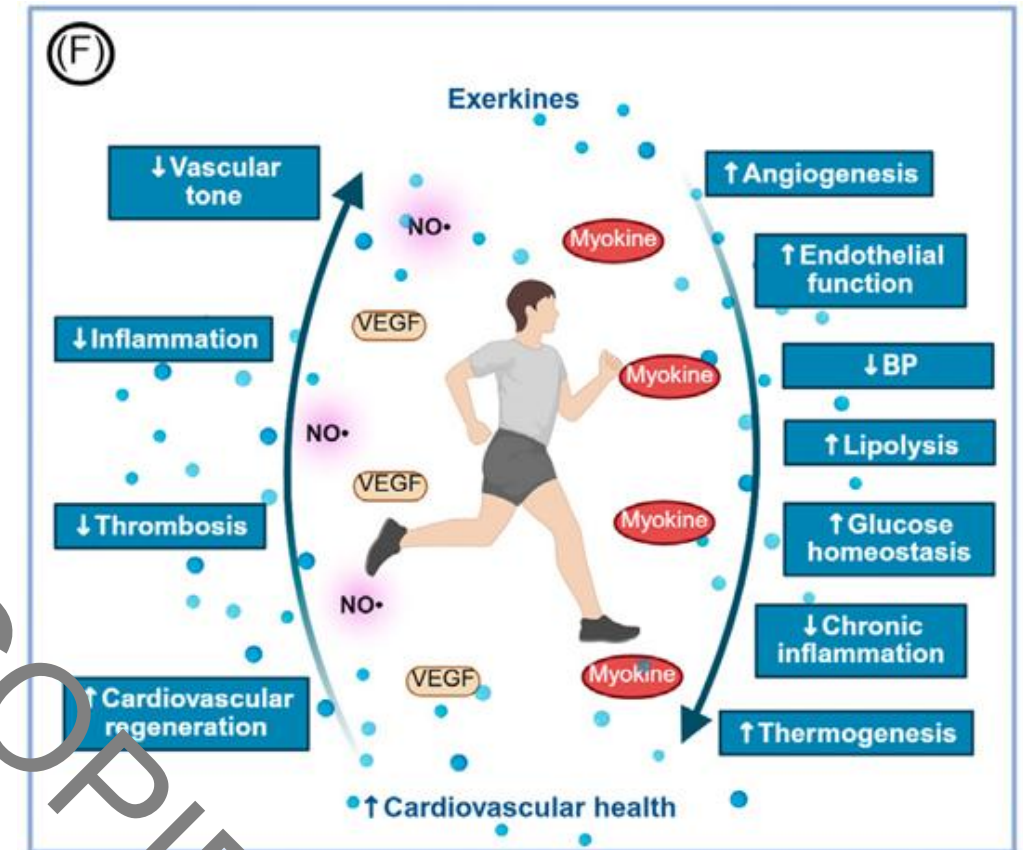
Regular physical activity exerts whole-body effects on primary and secondary CVD and metabolic health

✓ Mitochondria, inflammation, vascular

Phytochemicals which partially mimic:

- ✓ Resveratrol
- ✓ Epicatechin in green tea, cacao and fruits
- ✓ Eugenol (cinnamon, basil, cloves and bay leaves) and urolithin A (from gut microflora)

Many benefits mimicked by sauna/heat



What activity do you enjoy?

Sleep apnoea - bidirectional relationship T2DM



Network meta-analysis of randomised trials moderate to severe OSA

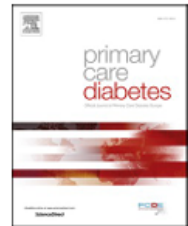
- ✓ 34 trials, nearly 4000 people Primary outcome Apnea Hypopnea Index (AHI)
- ✓ CPAP significantly ↓ Apnea Hypopnea Index (-22.17 events/hour v no treatment), daytime sleepiness;
- ✓ GLP-1RAs most impact on BMI and HbA1c reduction No significant changes in BP or fasting glucose

Chiappa et al 2026; 28: 3557-3567

Older adults with sub-optimal glycaemic control and insomnia high prevalence undiagnosed OSA

- ✓ 90% OSA; 1 in 2 had Moderate/Severe OSA on home testing (AHI≥15)
- ✓ Diagnosis and CPAP adherence can improve HbA1c 0.24% (3mmol/mol); weight loss also important

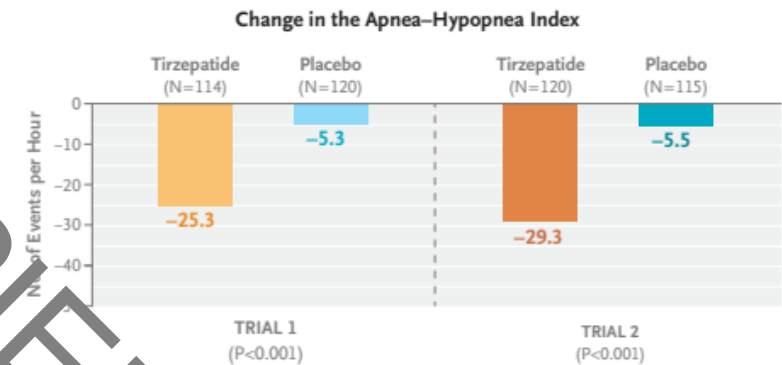
Kwan et al Primary Care Diab 2026; 20:80-87



Tirzepatide for sleep apnoea and obesity +/- CPAP

- ✓ Obesity and OSA (AHI >15/hour) but no T2DM
- ✓ Tirzepatide v placebo Trial 1 – no CPAP Trial 2 – CPAP

Malhotra et al NEJM 2024; 391: 1193-1205



Do we ask about insomnia, snoring and apnoea and use questionnaires (STOP BANG, Epworth Sleepiness Scale)?

How many people with diabetes or obesity have we referred for sleep studies this year?

DVLA – Assessing Fitness to drive

HOW TO ASSESS FITNESS TO DRIVE

Assessing fitness to drive

Group 2 drivers (large lorries [category C] and buses [category D])
In most cases, the medical standards for Group 2 drivers are substantially higher than for Group 1 (car and motorcycle) drivers. This is because of the size and weight of the vehicle and the length of time an occupational driver typically spends at the wheel.
Note: Drivers with a Group 1 category B licence issued before 1 January 1997 have additional driving entitlements until the licence expires or is revoked for medical reasons: [see here](#).

Taxi and emergency vehicle drivers
The DVLA states that the same medical standards apply for drivers of taxis and police, fire, coastguard, ambulance and health service vehicles as for drivers of regular vehicles. However, individual forces, services or council licensing bodies may impose higher medical standards over and above these licensing requirements.

Diabetes treated by diet or lifestyle alone	
Group 1 Car and motorcycle	Group 2 Bus and lorry
May drive and need not notify the DVLA, provided the driver meets the requirements in leaflet INF188/2.	May drive and need not notify the DVLA, provided the driver meets the requirements set out in leaflet INF188/5.
Must have no disqualifying complications of diabetes.	Must have no disqualifying complications of diabetes.

Diabetes treated by medication other than insulin		
	Group 1 Car and motorcycle	Group 2 Bus and lorry
Managed by tablets carrying hypoglycaemia risk (includes sulfonylureas and glimepiride)	<p>May drive and need not notify the DVLA, provided the driver:</p> <ul style="list-style-type: none"> Has adequate awareness of hypoglycaemia (being able to recognise symptoms in time to safely stop the vehicle). Has not experienced two or more episodes of severe hypoglycaemia while awake in the last 12 months and the most recent episode occurred more than 3 months ago. Is under regular review. Has no disqualifying complications of diabetes. <p>It is advisable to practice appropriate glucose monitoring at times relevant to driving to enable the detection of hypoglycaemia. If required, notify DVLA by completing form V30AB/15G.</p>	<p>May drive but must notify the DVLA. All the following criteria must be met for DVLA to issue a licence for 1, 2 or 3 years:</p> <ul style="list-style-type: none"> No episode of severe hypoglycaemia in the last 12 months. Full awareness of hypoglycaemia. Regular self-monitoring of glucose – at least twice daily and at times relevant to driving, such as at the start of the first journey and at least every 2 hours during the journey (CGM is accepted but must also carry a fingerstick meter as a backup). Demonstrates an understanding of the risks of hypoglycaemia. Under regular medical review. Has no disqualifying complications of diabetes. <p>If required, notify DVLA by completing form V30AB/15G.</p>
Managed by other medications (includes metformin, DPP-4i, SGLT2i, GLP-1 RAs and non-insulin injectables)	<p>May drive and need not notify the DVLA, provided the requirements set out in leaflet INF188/2 are met and the driver is under regular medical review.</p> <p>Must have no disqualifying complications of diabetes. If required, notify DVLA by completing form V30AB/15G.</p>	<p>May drive but must notify the DVLA. DVLA may issue a licence if the requirements set out in leaflet INF188/2 are met and the driver is under regular medical review.</p> <p>Must have no disqualifying complications of diabetes. If required, notify DVLA by completing form V30AB/15G.</p>

What and why
The Drivers' Medical Section within the DVLA deals with all aspects of driver licensing when there are medical conditions that impact or potentially impact safe control of a vehicle.
A driver can be fined up to £1000 if they fail to notify the DVLA about a medical condition that affects their driving and may be prosecuted if they are involved in an accident as a result. This summarises guidance for healthcare professionals (HCPs) based on the November 2025 update of *Assessing Fitness to Drive*, available at <https://bit.ly/dvla/fitstodrive>.

Doctors and other healthcare professionals should:

- Advise the individual on the impact of their medical condition on safe driving ability.
- Advise the individual of their legal requirement to notify the DVLA of any relevant condition, or if they meet the notification criteria in [Box 1 \(page 3\)](#) or start insulin therapy.
- Provide the information leaflets: INF188/2 for drivers treated with non-insulin medications, diet or both; INF294 for those treated with insulin; and INF186 for those wishing to apply for Group 2 entitlement.
- Notify the DVLA directly of an individual's medical condition or fitness to drive if they cannot or will not notify the DVLA themselves (see GMC guidance on confidentiality and reporting to the DVLA).
- HCPs should always record in their consultation notes that advice has been provided regarding driving and diabetes, especially with respect to fitness to drive, hypoglycaemia risk and appropriate glucose monitoring.
- All HCPs who provide guidance on diabetes should familiarise themselves fully with chapter 3 of *Assessing Fitness to Drive* and other sections as appropriate, and discuss with colleagues on the DVLA Medical Team if they are uncertain about how to interpret guidance in relation to individual patients.

NOT TO BE COPIED

Both group 1 and 2 can now use CGM

- ✓ Capillary reading if <4, hypoglycaemia symptoms, CGM not reflecting symptoms
- ✓ Alarms supplement, not replace awareness
- ✓ Group 2 must stop driving and notify if insulin initiated
- ✓ HCPs should:
 - ✓ advise of legal requirement to notify DVLA relevant condition or meet notification criteria
 - ✓ Provide leaflets appropriate to drug therapies
 - ✓ Follow GMC guidance if person cannot/will not notify
 - ✓ Record guidance provided in notes
 - ✓ Discuss with DVLA medical team if uncertainties



Leaflets – links on the How to



Remember

- ✓ CVD, renal conditions
- ✓ Vision problems
- ✓ OSA and sleepiness
- ✓ Limb problems

Want to practice initiating conversations about obesity?



Try out the 'Treating Obesity First' resource 'Practice Conversations in Obesity Care'

- ✓ Based on the Canadian 5As framework of Ask, Assess, Advise, Agree, Arrange
- ✓ Allows multiple conversation inputs with immediate patient responses
- ✓ Provides feedback at conversation end and scores the conversation, to ensure real time learning

OMAr AI Patient Conversation Simulator

Practice Conversations in Obesity Care

Simulate patient visits, practice the 5A framework, and receive coaching feedback after the visit ends.

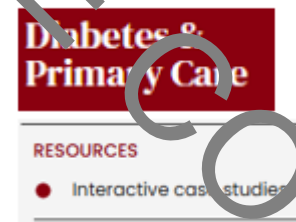
This is an AI-generated training tool for education only. It is not a real patient and does not provide medical advice.

Choose a Patient Persona

- Omar H.**
Man - Age 46
Busy adult balancing work, health concerns, and mixed past experiences
Busy schedule
Past frustration
Wants practical help
- Angela S.**
Woman - Age 48
Prior weight stigma in healthcare
Past stigma
Pain + fatigue
Wants respect
- Jordan L.**
Woman - Age 34
Caregiver under pressure and struggling to prioritize herself
Overwhelmed
Low energy
Needs support
- David T.**
Man - Age 67
Older adult with mobility limitations
Mobility limits
Joint pain
Practical
- Sofia M.**
Woman - Age 42
Motivated patient actively seeking treatment options
Motivated
Ready for plan
Wants options

<https://treatingobesityfirst.org/patient-conversation-simulator/>

Want to practice clinic scenarios in a safe environment? Thanks to David Morris



Peripheral artery disease and diabetes

The causes, diagnosis and management of PAD.

27 Nov 2025

Early pharmacological treatment in type 2...

Optimised management of glycaemia and cardiorenal risk factors yields long-term benefits.

17 Feb 2025

GLP-1 and GIP/GLP-1 receptor agonists in type ...

The practicalities of prescribing incretin-based therapies for the management of type 2 diabetes.

13 Aug 2025

Managing acute illness in type 2 diabetes

Sick day rules and the prevention and identification of hyperglycaemic emergencies and acute kidney injury.

3 Dec 2024

Type 2 diabetes and fatty liver disease

This scenario covers fatty liver disease, including its causes, diagnosis and management.

4 Jul 2025

Diabetes on the net www.diabetesonthenet.com

AT A GLANCE FACTSHEET

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

NICE overweight and obesity
guidelines – what's new?



All free

Managing multiple long-term conditions in 2026: The power of integrated healthcare

3rd London Conference | PCDO Society

London PCDOS 2026
RCGP, London
Join us face-to-face in London
01.07.26
FACE-TO-FACE



bitly

Journal of
Diabetes Nursing

The Diabetic
Foot Journal

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From complexity to clarity:
Practical insights to provide
the best possible care

Smart RADIATION | PCDO Society

PCDOS Smart Updates 2026
Birmingham, Manchester, London
18.06.26, 22.06.26 & 09.09.26
Join us face-to-face
FACE-TO-FACE

Unravelling the complexities
of care: Diabetes, obesity
and associated conditions

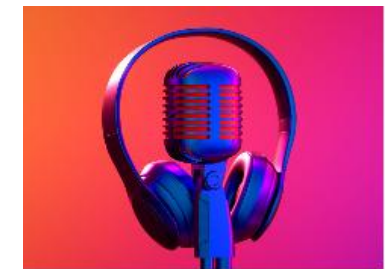
22nd National Conference | PCDO Society

National PCDOS 2026
NCC, Birmingham
18.11.2026 & 19.11.2026
Join us face-to-face in Birmingham
FACE-TO-FACE

Diabetes & Primary Care

RESOURCES

- Interactive case studies
- Adaptation factsheets
- How-to series
- Need-to-know series
- Prescribing pearls
- Diabetes Distilled
- Q&As



PCDO Society podcast:
Episode 1 – The updated
NICE NG28 guideline



PCDO

Society

New podcast
series



NOT TO BE COPIED

Knowledge, if combined
with action, really can
change lives.

What will we do
differently tomorrow?

Diabetes distilled - an e-newsletter from the Primary Care Diabetes and Obesity Society designed to share the latest developments in diabetes and obesity for primary care teams. We summarise the latest papers that matter.

Sign up to receive the Diabetes Distilled newsletter at the link below



Diabetes Distilled: Incretin therapies and endoscopy safety

Risk of residual gastric volume seen in people taking injectable incretin agents prior to endoscopy.

20 Apr 2026



Diabetes Distilled: Greater reductions in HbA1c ACHIEVED with orforglipton versus oral semaglutide 14 mg

Greater efficacy at the cost of more adverse events in this developmental oral GLP-1 receptor agonist.

2 Apr 2026



Diabetes Distilled: Weight regain after stopping newer weight management drugs is faster than anticipated

Weight returns to baseline levels an estimated 1.5 years after stopping semaglutide or tirzepatide.

23 Mar 2026



Diabetes Distilled: SUPAS-CVOT - Tirzepatid demonstrates cardiovascular benefit in secondary prevention

3-point MACE occurred in 12.2% vs 13.1% of tirzepatide and dulaglutide recipients, respectively, confirming non-inferiority.

6 Mar 2026



Diabetes Distilled: Shared decision-making can improve obesity care in people with type 2 diabetes

Why is shared decision-making important, what barriers are there and what tools can support it?

6 Mar 2026



Diabetes Distilled: Statins effective for primary cardiovascular prevention at all risk levels in type 2 diabetes

Findings should motivate us to encourage statin initiation and persistence for primary prevention in more people with type 2 diabetes.

6 Mar 2026