



From the desk of the chairman, Ketan Dhatariya

Professor Ketan Dhatariya, Chair of the ABCD Executive, reflects on recent progress, key achievements and the organisation's priorities for 2026

As Chair of the Association of British Clinical Diabetologists (ABCD), it is always a pleasure to share an overview of our recent work. It has been a period marked by visible impact as well as important developments behind the scenes.

A significant focus this year has been behind the scenes, with a review, audit and implementation of strengthened internal controls and governance processes. As many of you will know, this important work required a temporary pause to the audit programme while an external auditor completed a Data Protection Impact Assessment (DPIA). The findings of this report, along with ongoing improvements, will reinforce our governance framework and ensure that future audit programmes meet the highest standards. We have also strengthened our internal appointment processes, introducing letters of agreement for all appointed positions.

ABCD continues to deliver high value resources, events, and guidance for members and the wider diabetes community. Planning is underway for this year's annual conferences, which will take place in Solihull on 4th to 5th November. The Diabetes Technology Network (DTN UK) meeting takes place on the 4th November, followed by ABCD Conference evening sessions that day and the full ABCD Conference on the 5th November. These meetings offer an excellent opportunity to explore the latest advances in diabetes research, clinical practice and technology, while also providing valuable time to connect with colleagues. Registration will open shortly at <https://abcd.care/events>.

ABCD will also deliver two regional

meetings in 2026: a collaborative meeting with EASE in Norwich on 15th June, and a second meeting in September in the Southampton area, to focus on community diabetes.

Details of all upcoming ABCD and DTN UK events can be found at <https://abcd.care/events>.

The long running ABCD Consultant Development Programme will take place at the RCP's The Spine in Liverpool this June. The course is fully subscribed, reflecting its continued popularity among specialty registrars (StRs) and newly appointed consultants. As part of our governance work, we have refined the programme and are working closely with the Royal College of Physicians to deliver an enhanced version carrying the RCP badge.

Alongside our in person meetings, we remain committed to providing high quality digital education. Webinar topics for 2026—including periodontal disease and AI in diabetes care—are available on demand at <https://abcd.care/abcd-webinars>, with additional topics to follow.

ABCD also maintains a strong presence at national and policy levels. Earlier this year, I wrote to the then Health Minister, Wes Streeting, to raise concerns about the withdrawal of funding for Type 1 disordered eating pilot site services. I encourage members to do the same so that equitable access to treatment is protected across the UK. I continue to raise issues affecting our specialty in several forums, including NHS England and the RCP.

Regrettably, the *British Journal of Diabetes* did not achieve PubMed status in 2025. However, our new Editors in Chief, Dr Ben Field and Dr Srikanth

Bellary, will lead the next phase of the journal's development, with a view to resubmission in 2027.

Our commitment to innovation remains strong. The Dragons' Den research programme has completed its latest round, with winners to be announced soon. We are also collaborating with the Novo Nordisk UK Research Foundation to offer a research fellowship aimed at advancing diabetes care. Applications have been reviewed and a decision has been made. The successful candidates will be notified in early Spring.

I was delighted to welcome new committee members—Dr Jason Cheung, Professor Muhammad Ali Karamat and Dr Punith Kempegowda—and I look forward to working with them to further ABCD's reach. A special welcome goes to our new Meetings Secretary, Dr Aaisha Saqib. This is a demanding and vital role within the Executive, central to delivering our highly valued education programme. We are deeply grateful to our outgoing Meetings Secretary, Kate Fayers, for her outstanding contribution over recent years. While she will be greatly missed, we look forward to the fresh ideas Aaisha will bring. I recently had the opportunity to meet several people she was at medical school with, and they could not stop singing her praises!

Looking ahead, ABCD will continue to build on the strong foundations laid by past and present members. We will expand our educational offerings, promote high quality research, strengthen partnerships and advocate for excellence in diabetes care. We will also explore opportunities for income generation by sharing our expertise

internationally. I extend my sincere thanks to all members, contributors and staff for their dedication and support during this period of growth and transformation.

Finally, ABCD expresses its deep appreciation to our sponsors and supporters. Your partnership enables us to deliver high quality education, research and advocacy for clinicians and

the wider diabetes community. Together, we are shaping a stronger, more innovative and more inclusive ABCD.

Professor Ketan Dhatariya
ABCD Chair, Norwich

From the desk of the News Editor, Professor Umesh Dashora

News from the Joint British Diabetes Societies for Inpatient Care (JBDS-IP) group (Omar Mustafa, chair JBDS-IP)

Guidelines and position statements

- Management of diabetes in people undergoing metabolic and bariatric surgery. Published in *Diabetic Medicine* <https://onlinelibrary.wiley.com/doi/10.1111/dme.70281>
- 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. Published in *Anaesthesia* <https://doi.org/10.1111/anae.16541>
- For all JBDS-IP publications and position statements check the JBDS-IP website and Google Scholar pages.
- **Coming soon:**
 - The use of variable rate intravenous insulin infusion (VRII) in medical inpatients. A major update of the 2014 document.
 - Use of diabetes technology in hospital. An update to the 2024 version.
 - Perioperative care of people with diabetes undergoing surgery, in collaboration with the Centre for Perioperative Care.

JBDS Inpatient Diabetes Conference 2026

- The JBDS Inpatient diabetes conference 2026 is going to be held at the Grand Hotel in Leicester on

Friday 3rd July, 2026. The conference will highlight the latest innovations, research and developments in inpatient diabetes care, providing delegates with valuable insights into best practice and emerging trends. In a new development for 2026, the event will be preceded by the inaugural launch meeting of the Diabetes Inpatient Study Group (DISG), a newly formed reference group of the European Association for the Study of Diabetes (EASD). This is a small, closed meeting taking place on the evening of Thursday 2nd July in Leicester. For registration and abstract submission see <https://abcd.care/events/jbds-ip-inpatient-diabetes-conference-2026>

Rowan Hillson Award 2025 (Umesh Dashora)

- The Rowan Hillson inpatient diabetes award is open for submissions for the 2026 round of awards. This prestigious national award has been running since 2014 and awards excellence in inpatient diabetes care. Are you at the forefront of inpatient diabetes care and demonstrating innovation? Shine a light on your team's achievements with the Rowan Hillson Inpatient Diabetes Award 2026. Visit the website for the submission form <https://abcd.care/current/rowan-hillson-inpatient-diabetes-awards>. The winning teams will be invited to present their innovations at the next ABCD/DTN conference in Solihull on 4-5 November, 2026. There will be free conference registration and travel for the winning teams. The project is led by Professor Umesh Dashora.

Keep up to date

Want to keep up to date with developments in inpatient diabetes? Join the JBDS-IP mailing list. <https://abcd.care/jbds-ip>

ABCD Meeting Secretaries Update – April 2026 (Aisha Saqib)

We were delighted to welcome 170 colleagues to the ABCD Diabetes Update held in January in Telford. This is now in its fourth year and is launching a new three year cycle aligned with the JRCPTB Diabetes Curriculum.

This June, we are excited to host the Consultant Development Programme, in collaboration with the Royal College of Physicians at The Spine in Liverpool.

Looking ahead, the ABCD Annual Conference will take place on Thursday 5th November 2026 in Solihull, with the DTN UK meeting the day before on Wednesday 4th November.

Two additional regional ABCD meetings are also planned for summer and autumn 2026.

We very much hope to see many of you at these events and look forward to an engaging and exciting year ahead for ABCD.

FreeDM2 randomised controlled trial published in *The Lancet Diabetes and Endocrinology* (Emma Wilmot and Lala Leelarathna)

NICE guidance recommends access to continuous glucose monitoring (CGM) for people living with type 1 diabetes (T1DM); for those with type 2 diabetes (T2DM), access is limited. A UK team led by Dr Lala Leelarathna and Dr Emma Wilmot recently published the FreeDM2 randomised controlled trial which demonstrates the benefits of CGM, compared to standard care, in adults with T2DM treated with basal insulin and

SGLT2 inhibitors and/or GLP-1 or GIP/GLP-1 receptor agonists.

The trial had two distinct phases: self-management up to four months followed by clinician support between 4-8 months where additional therapies could be added as required. This large trial, with more than 300 participants recruited from 24 UK sites, demonstrated clinically and statistically significant between-group differences in HbA_{1c} at 4 (-0.6%) and 8 (-0.5%) months. There were corresponding improvements in sensor glucose metrics and, importantly, no increase in hypoglycaemia. At four months there were improvements in accelerometer-measured physical activity and diet questionnaire responses, although between-group differences were not maintained at eight months. The intervention arm had greater glucose monitoring satisfaction and hypoglycaemia management confidence. A dedicated UK-specific health economic evaluation is underway. This important UK trial provides the much needed evidence to support expanded access to CGM in people living with T2DM treated with basal insulin and modern therapies.

Wilmot E, Moore P, Sathyapalan T, et al. Continuous glucose monitoring versus self-monitoring of blood glucose in individuals with type 2 diabetes: a randomised, multicentre, open-label, superiority trial. *Lancet Diabetes Endocrinol* 2026; [https://doi.org/10.1016/S2213-8587\(26\)00076-8](https://doi.org/10.1016/S2213-8587(26)00076-8)

Diabetes update (Roy Taylor)

Video of the 2024 Claude Bernard lecture is now freely available on the EASD website on demand.

There are three further papers published from my ongoing work:

1. Kusinski LC, Atta N, Jones DL, et al. Continuous glucose monitoring metrics and pregnancy outcomes in women with gestational diabetes: results from the DiGest trial. *Diabetes Care* 2025. <https://doi.org/10.2337/dc25-0452>
2. Dib S, Kusinski LC, Jones DL, et al. Energy restriction, weight loss, glycemia, and breastfeeding outcomes in gestational diabetes: a DiGest trial secondary analysis. *Diabetes Care* 2025. <https://doi.org/10.2337/dc24-2625>
3. Epstein B, Chadwick J, Carpenter

MA, et al. A proteomic tool suggests reductions in dementia risk following intentional weight loss in type 2 diabetes. *Alzheimer's Dement* 2025;21(Suppl. 7):e108444.

Health Service Safety Investigation Body (Daniel Flanagan)

The Health Service Safety Investigation body (HSSIB) have just released their report into insulin safety in hospital. The HSSIB have taken a year to talk to those involved in the development of standards, the monitoring of standards and the delivery of health care. They have talked to the regulators of health care and, most importantly, people with diabetes attending hospital for care. They highlight unresolved areas such as problems with implementing self-management in hospital for people with diabetes and problems with checking blood glucose on admission to hospital. Most importantly, they describe a lack of coordination in ensuring recommendations and standards are uniformly applied. They have concluded that there is a gap between the development of standards and the national monitoring of high-quality care. The challenge now is to use this work to produce measurable change. Persistent risks to safe insulin care in hospitals visit <https://www.hssib.org.uk/news-events-blog/persistent-risks-to-safe-insulin-care-in-hospitals/>

NHS England launches new audit of inpatient care (Daniel Flanagan)

NHS England is replacing the National Diabetes Inpatient Safety Audit with a comprehensive audit of care in hospital for people with diabetes. The audits standards are currently being worked on but will include measures of how care is provided as well as incidents and harm. An expert group has been established and will consider the pros and cons of previous audits such as NADIA. The new audit will be closely linked with the Diabetes Care Accreditation Programme run by the Royal College of Physicians and the Joint British Diabetes Societies inpatient group. It is hoped that information technology can be used to reduce the burden of data collection on

clinical staff. More details will be available later this year.

Diabetes update (Rebecca Reeve)

Increase in NICE QALY cost effectiveness threshold (UK)

What has changed?

For the first time in more than 20 years, the cost effectiveness threshold used by the National Institute for Health and Care Excellence (NICE) to assess new medicines for NHS use is being formally increased.

- Previous long standing threshold: £20,000–£30,000 per QALY gained
- New standard threshold (from April 2026): £25,000–£35,000 per QALY gained

This represents an effective ~25% increase in the NHS's willingness to pay for one additional quality adjusted life year (QALY) when evaluating new medicines.

Why is this happening?

The change is government led, not a NICE methodological revision. It was agreed as part of the UK-US Economic Prosperity Deal (December 2025), intended to:

- Improve the UK's attractiveness as a launch and investment market
- Support the life sciences sector
- Reduce trade and tariff pressures on UK pharmaceutical exports

To enable this, ministers have been granted new powers to direct NICE on the core threshold level, formalised through amendments to NICE's governing regulations (effective March 2026).

What does this mean in practice?

- NICE estimates that the higher threshold could allow 3–5 additional medicines or indications per year to be recommended for NHS use that might previously have been considered not cost effective.
- The change applies to Technology Appraisals from April 2026 onwards.

- It does not replace or affect:
 - The severity modifier (introduced in 2022)
 - Highly Specialised Technologies (HST) thresholds (≈£100,000–£300,000/QALY)
 - NICE's requirement to consider budget impact and affordability constraints.

Important contextual point

Health economists and policy experts emphasise that increasing the threshold increases access to higher cost medicines but may also increase opportunity costs elsewhere in the NHS unless additional funding is provided centrally.

Interesting recent research

Umesh Dashora, Md Mizanour Rahman, Nebras Hasan, Michael Vanner

A rapid-fire collection (extract) of interesting recent developments in diabetes

Authors, Journal	Type of Study	Main results
Tsameret <i>et al</i> , <i>Diabetologia</i>	Randomised crossover trial	<p>Benefits of high-protein dairy breakfast</p> <p>Participants on dairy-based protein source (YesMilk) phase upregulated key circadian clock genes (BMAL1, REV-ERBa, CRY1, PER1) compared to NoMilk phase. Glycaemic variables improved under the YesMilk diet, with fasting glucose down by 1.7 mmol/L, glucose management indicator reduced by 0.7%, and time in range increased by 9% compared with baseline. Hunger and sweet craving scores were reduced by 15-20%.</p> <p><i>Tsameret S, Froy O, Matz Y, et al. Glycaemic, appetite and circadian benefits of a dairy-enriched diet with high-protein breakfast and early daytime-restricted carbohydrate intake in type 2 diabetes: a randomised crossover trial. Diabetologia 2026;69(4):1021-1034. https://doi.org/10.1007/s00125-025-06658-2. Epub 2026 Jan 23. PMID: 41578008; PMCID: PMC12957644.</i></p>
Verhoog <i>et al</i> , <i>Diabetologia</i>	Review	<p>SHBG has an independent role in increasing the risk of diabetes</p> <p>This effect may be independent of sex steroids. This review compiles all the studies and mechanisms by which androgens and oestrogens and sex-hormone binding globulin (SHBG) may affect insulin sensitivity. Androgens increase the risk while oestrogen decreases the risk of developing diabetes. SHBG controls the availability of these steroids to insulin-sensitive tissues. In addition, SHBG independently reduces the risk of developing diabetes.</p> <p><i>Verhoog NJD, Africander D, Storbeck KH. Sex steroids, SHBG and type 2 diabetes in women: what do we really know? Diabetologia 2026;69(4):837-854. https://doi.org/10.1007/s00125-025-06647-5. Epub 2026 Jan 15. PMID: 41535596.</i></p>
Bangshaab <i>et al</i> , <i>Diabetologia</i>	Randomised crossover study	<p>Ketone supplementation can improve diabetes</p> <p>Ketone monoester (KE) and ketone salts reduced the glucose area under the curve (AUC) by 30% and 22%, respectively. Both ketones lowered postprandial non-esterified fatty acids and ghrelin concentrations and ketone esters reduced triglycerides. KE dose-dependently lowered the AUC of glucose, with the strongest effect when ingested 30 minutes or 60 minutes before the oral glucose tolerance test. Transient mild gastrointestinal symptoms were the only side effects noted.</p> <p><i>Bangshaab M, Bengtson MB, Smedegaard S, et al. Ketone supplementation dose-dependently lowers postprandial blood glucose, lipid and ghrelin levels in individuals with type 2 diabetes: a randomised crossover study. Diabetologia 2026;69(3):752-763. https://doi.org/10.1007/s00125-025-06614-0. Epub 2025 Nov 28. PMID: 41315088.</i></p>
Lal <i>et al</i> , <i>Diabetologia</i>	Review	<p>Can people with type 1 diabetes do fully closed-loop system themselves?</p> <p>This review evaluates the current position and understanding of fully automated insulin delivery systems without the need to announce meals. These open-source automated systems seem to manage glucose effectively, with a reduced burden on people with diabetes. However, there are challenges in managing periods of fluctuating insulin sensitivity such as exercise and following predicted low glucose.</p> <p><i>Lal R, Braune K, Lewis DM, Petruzelkova L, de Bock M, Hussain S. Fully closed-loop systems: can people with type 1 diabetes just do it? Insights from open-source systems. Diabetologia 2026;69(3):557-567. https://doi.org/10.1007/s00125-025-06644-8. Epub 2026 Jan 19. PMID: 41555051; PMCID: PMC12881006.</i></p>
Spies <i>et al</i> , <i>Diabetologia</i>	Short communication	<p>Post-OGTT hypoglycaemia can occur in 8% of newly diagnosed people with type 2 diabetes</p> <p>In this study on 97 extended OGTTs from individuals with newly diagnosed type 2 diabetes (T2DM) hypoglycaemia (glucose <3.9 mmol/L) occurred in 8.2% of subjects. People who exhibited hypoglycaemia had significantly lower BMI and higher insulin sensitivity, without any differences in beta cell function. All these individuals were assigned to the mild obesity or age-related diabetes clusters.</p> <p><i>Spies R, Ufer G, Sabia R, Hummel J, Peter A, Wagner R, Heni M. Post-OGTT hypoglycaemia in newly diagnosed type 2 diabetes: frequency, characteristics and cluster assignment. Diabetologia 2026. https://doi.org/10.1007/s00125-026-06719-0. Epub ahead of print. PMID: 41896315.</i></p>

Authors, Journal	Type of Study	Main results
McClure <i>et al</i> , <i>Diabetologia</i>	Randomised crossover comparison	<p>Glycaemic response to morning-fasted (AM-FAST) resistance exercise is more consistent than the response to afternoon-fed (PM-FED) resistance exercise in people with type 1 diabetes</p> <p>The change in within-participant standard deviation in capillary blood glucose (CBG) was lower for AM-FAST (1 mmol/L) compared to PM-FED (1.5mmol/L). During exercise CBG increased by 1.4 mmol/L for AM-FAST and decreased by 0.9 mmol/L for PM-FED. There was a greater percentage of time in hyperglycaemia in the 6- hour post-exercise period following AM-FAST vs PM-FED (56.7% vs 33%).</p> <p><i>McClure RD, Carr ALJ, Boulé NG, Yardley JE. The glycaemic response to morning fasted resistance exercise is more consistent than the response to afternoon fed resistance exercise for adults with type 1 diabetes: a randomised crossover comparison. Diabetologia 2026. https://doi.org/10.1007/s00125-026-06713-6. Epub ahead of print. PMID: 41831023.</i></p>
Gu <i>et al</i> , <i>Diabetes Obesity and Metabolism</i>	Prospective cohort study	<p>Oxidised lipoproteins are independent, dose- dependent predictors of T2DM development in individuals with pre-diabetes</p> <p>This multicentre, prospective cohort study enrolled 3,056 participants including 1,521 individuals with pre-diabetes who were followed for five years. Elevated baseline levels of lipoproteins (ox-HDL-C, ox-LDL-C) were independently associated with increased odds and hazard ratios for progression from prediabetes to T2DM. Oxidised lipoproteins were correlated positively with FBG, HbA1c and HOMA-IR and negatively with HOMA-beta and HOMA-IS, suggesting a relationship with beta cell dysfunction and insulin resistance. These findings highlight their potential utility in early risk stratification and targeted prevention strategies for T2DM.</p> <p><i>Gu JX, Huang J, Zhang AM, et al. Oxidised lipoproteins and the risk of type 2 diabetes mellitus: a 5-year cohort study on beta-cell dysfunction and prediabetes progression. Diabetes Obes Metab 2026;28(5):3632-3643. https://doi.org/10.1111/dom.70540. Epub 2026 Feb 9. PMID: 41657116.</i></p>
Izarra <i>et al</i> , <i>Diabetes Obesity and Metabolism</i>	Prospective cross-sectional study	<p>Prediabetes is independently associated with early renal impairment and accelerated kidney function decline: insights from the ILERVAS cohort</p> <p>Analysis used data from 8,153 participants in ILERVAS cohort in a prospective cross-sectional study. Prediabetes was defined as HbA1c 5.7%-6.4% (ADA criteria). Kidney impairment was defined as eGFR <60 ml/min/1.73m² or urinary albumin creatinine ration (ACR) ≥30mg/g at a single time point. At baseline, prediabetes was associated with higher kidney impairment prevalence (17.8% vs 13.7%; p<0.001), lower eGFR and increased ACR. Each 1% increase in HbA1c was linked to a 4.6 ml/min/1.73m² decrease in eGFR. At follow-up, prediabetes predicted further eGFR decline and an increase was independently associated with eGFR decline.</p> <p><i>Izarra A, Bermúdez-López M, Valdivielso JM, et al; ILERVAS project collaborators. Baseline and 4-year associations between prediabetes and kidney impairment: Insights from the ILERVAS cohort. Diabetes Obes Metab 2026;28(5):3777-3787. https://doi.org/10.1111/dom.70560. Epub 2026 Feb 18. PMID: 41705635; PMCID: PMC13071258.</i></p>
Ipaye <i>et al</i> , <i>Diabetes Obesity and Metabolism</i>	Retrospective cohort study	<p>SGLT-2i and obesity-associated cancers in people with type 2 diabetes: a real-world observational study</p> <p>This retrospective cohort study used data from the TriNetX US Collaborative Network in which individuals with T2DM initiating SGLT-2i were compared with those initiating DPP-4i. A lower rate of renal cancer was observed in the overall population (HR 0.78; CI 95% CI 0.67-0.92), while a higher rate of thyroid cancer was observed in the overall population (1.37; 1.06-1.76). Initiation of SGLT-2i was not associated with higher or lower rates of OAC compared with DPP-4i. However, initiation of SGLT-2i was associated with modestly lower rates of all the cancer outcomes, the clinical significance of which remains unclear.</p> <p><i>Ipaye T, Goldney J, Yates T, et al. Sodium-glucose co-transporter 2 inhibitors and obesity-associated cancers in people with type 2 diabetes: A real-world observational study. Diabetes Obes Metab 2026;28(5):3807-3818. https://doi.org/10.1111/dom.70562. Epub 2026 Feb 26. PMID: 41749411; PMCID: PMC13071211.</i></p>
Wang <i>et al</i> , <i>Diabetes Obesity and Metabolism</i>	Prospective single-arm interventional study	<p>Post-semaglutide weight regain (WR) in females with obesity: association with gut-derived signals in reactivation of central appetite pathways. A basis for investigation to achieve sustained weight loss</p> <p>28 women with obesity finished 36 weeks of semaglutide treatment (2.4mg/week) followed by 12-week withdrawal. Parallel animal studies used HFD-fed female rats, with 4-week semaglutide intervention and 4-week withdrawal. During treatment, patients achieved significant weight loss (-16.9±4.8kg) but 71.4% exhibited WR (+5.1±1.6 kg) post-withdrawal and 78.5% reported appetite rebound. Animal studies showed post-withdrawal gut microbiota dysbiosis, decreased ursodeoxycholic acid and downregulated hypothalamic TGR5 expression.</p> <p>The recurrence of WR and increased appetite after semaglutide withdrawal coincided with reversals in gut microbiota and related metabolic profiles. These changes provide a basis for investigating strategies to sustain weight loss.</p> <p><i>Wang N, Guo H, Song L, et al. Post-semaglutide weight regain in females with obesity: associations with gut microbiota, bile acid metabolism, and central nervous system. Diabetes Obes Metab 2026;28(5):3903-3916. https://doi.org/10.1111/dom.70571. Epub 2026 Feb 18. PMID: 41705640.</i></p>

Authors, Journal	Type of Study	Main results
Bourron <i>et al</i> , <i>Diabetes Obesity and Metabolism</i>	Meta-analysis	<p>Once-weekly (OW) insulins in type 2 diabetes modestly improve glycaemic control without increasing hypoglycaemic risk. A systematic review and meta-analysis</p> <p>The review searched PubMed, WoS, ClinicalTrials.gov and EU clinical Trials database up to June 2025 for RCTs evaluating once-weekly (OW) insulins in type 2 diabetes (T2DM). Among 435 screened records, 16 RCTs were included. OW insulins achieved greater reductions in HbA1c compared to once-daily insulin or semaglutide. TIR was significantly longer (+24% of total time, 95% CI), with similar hypoglycaemia incidence (pooled incidence ratio 1.04, CI95%) and slight weight gain (+0.33kg, 95%CI).</p> <p><i>Bourron O, Denimal D. Efficacy and safety of once-weekly insulins in type 2 diabetes: a systematic review and meta-analysis. Diabetes Obes Metab 2026;28(5):3491-3501. https://doi.org/10.1111/dom.70497. Epub 2026 Jan 23. PMID: 41574970; PMCID: PMC13071184.</i></p>
D. Russell-Jones <i>et al</i> , <i>Diabetes Obesity and Metabolism</i>	Randomised crossover study	<p>Glucose and beta hydroxybutyrate combination (FLO23011), a novel agent, provides superior hypoglycaemia management in type 1 diabetes through improved glycaemic stability, reduced recurrence: outcome of two randomised crossover studies</p> <p>Two studies, study A, a randomised, crossover pharmacokinetic investigation in six healthy adults and study B, a 12-week randomised, open-label, crossover clinical trial in 12 adults with T1DM comparing FLO2301 versus standard glucose treatment, were analysed. Study A demonstrated comparable glucose response but FLO23011 resulted in sustained beta-hydroxybutyrate elevation. Study B demonstrated significantly improved post-hypoglycaemia TIR (82.5% vs 77%, p=0.019) and reduced recurrent episodes by 27% (p=0.031).</p> <p><i>Russell-Jones D, Smout V, Roy S, Myers G, Littlewood R, Shajae-Moradie F. A novel glucose beta-hydroxybutyrate combination improves hypoglycaemia recovery and patient-reported outcomes in type 1 diabetes. Diabetes Obes Metab 2026;28(5):3590-3597. https://doi.org/10.1111/dom.70323. Epub 2025 Dec 8. PMID: 41362024; PMCID: PMC13071251.</i></p>
Boege <i>et al</i> , <i>Diabetic Medicine</i>	Population-based study	<p>Suboptimal postpartum diabetes screening in the USA</p> <p>In this study the authors reported overall weighted prevalence of postpartum diabetes screening at 55.8%. Screening prevalence increased from 2016 (55.6%) to 2019 (60.3%), declined at the onset of the COVID-19 pandemic (2020:52.6%) and subsequently increased through 2022 (55.8%). Screening prevalence was higher among women over 30 years of age, in ethnic groups, those who did not graduate from high school, had public prenatal health insurance, had pre-pregnancy overweight or obesity and had adequate prenatal care. Screening prevalence was 5 to 14% lower among individuals with a previous live birth, preterm birth and residents of rural areas.</p> <p><i>Boege HL, Berube LT, Ryan RA, Deierlein AL. Receipt of postpartum diabetes screening after gestational diabetes mellitus in the United States, 2016-2022. Diabet Med 2026:e70327. https://doi.org/10.1111/dme.70327. Epub ahead of print. PMID: 41963768.</i></p>
Olsen <i>et al</i> , <i>Diabetic Medicine</i>	Observational study	<p>Association of continuous glucose monitoring-based glucose levels with mortality and ICU admissions in hospitalised patients with AKI</p> <p>In this analysis authors showed that AKI was correlated with a 7.3%-point reduction in time in range due to an increase in time above range with no significant change in time below range. AKI was also associated with a ten-fold increase in the risk of in-hospital mortality and ICU admissions. Risk of readmission within 30 days also doubled in the AKI group.</p> <p><i>Olsen MT, Nørgaard K, Jensen SH, et al. Acute kidney injury in hospitalised patients with type 2 diabetes: associations with continuous glucose monitoring-based glucose levels, mortality, and ICU admission. Diabet Med 2026:e70321. https://doi.org/10.1111/dme.70321. Epub ahead of print. PMID: 41964006.</i></p>
Rayman <i>et al</i> , <i>Diabetic Medicine</i>	National survey	<p>Variations in service delivery for inpatient diabetes care in England</p> <p>Most hospitals reported a continued increase in inpatient numbers since 2019. Although most hospitals reported access to Diabetes Inpatient Specialist Nurses (DISNs), nearly two-thirds had no weekend DISN service. Access to diabetes physician support and out-of-hours specialist advice was limited. The use of networked glucose monitoring systems was widespread but their use for quality improvement was inconsistent. Trusts with higher staffing levels demonstrated shorter length of stay and fewer 30-day emergency readmissions.</p> <p><i>Rayman G, Johnston P, Earnshaw F, Kar P, Briggs TWR, Gray WK. Changing trends and variation in service delivery for inpatient diabetes care in England: a national survey. Diabet Med 2026:e70320. https://doi.org/10.1111/dme.70320. Epub ahead of print. PMID: 41964120.</i></p>
Richardson <i>et al</i> , <i>Diabetic Medicine</i>	Consensus statement	<p>Competency framework for skills in using hybrid closed loop, insulin pump systems and continuous glucose monitoring devices</p> <p>The group has developed a four-level training and competency framework using the 'Novice to Expert' framework and identified skills and competencies required for each level. National organisations have endorsed this framework. This will help to achieve the NHS implementation plan for HCLs to be offered for all people with type 1 diabetes within five years.</p> <p><i>Richardson E, Stribling B, Ridgeway J, et al. A consensus statement on a National Competency Framework for training and assessment of knowledge and skills in diabetes technologies, including hybrid closed loop (HCL), insulin pump systems, and continuous glucose monitoring (CGM) devices. Diabet Med 2026:e70253. https://doi.org/10.1111/dme.70253. Epub ahead of print. PMID: 41943214.</i></p>

Authors, Journal	Type of Study	Main results
Wilson <i>et al</i> , <i>Diabetic Medicine</i>	Epidemiological study	<p>Fasting glucose at 28 weeks in pregnant women is associated with poor development outcome in the offspring</p> <p>In this study of 13,627 children from the UK's Born in Bradford cohort, higher fasting glucose at 26-28 weeks of gestation was associated with an increased risk of failing to achieve a good level of development in children. The association was stronger in children of Pakistani ethnicity compared to White British ethnicity. There was no association with 2-h post-load glucose or gestational diabetes diagnosis.</p> <p>Wilson CA, Santorelli G, Simonoff E, Howard LM, Ismail K, Reynolds RM. Maternal glycaemia and child educational attainment at age 5 in the Born in Bradford cohort. <i>Diabet Med</i> 2026:e70317. https://doi.org/10.1111/dme.70317. Epub ahead of print. PMID: 41936124.</p>
Dumortier <i>et al</i> , <i>Diabetes Care</i>	Retrospective cohort	<p>Effects of sodium–glucose cotransporter 2 inhibitor use on mortality, amputation and healing in patients with diabetic foot ulcer</p> <p>The evidence with regard to the risk of amputation with the use of SGLT2i in diabetic foot ulcers is conflicting. Some studies show an increased risk of lower limb amputations, while EMPA-REG and DECLAE-TIMI58 trials did not demonstrate such a link. In this retrospective study, 452 patients with new diabetic foot ulcers were included, and were followed up for a year. The study did not show an increase in the amputation rate in patients on SGLT2i (treated or not treated 20.9% vs. 22.9%, respectively; $p = 0.687$). The 6-month healing time was significantly lower in patients treated with an SGLT2i vs those not treated: 136.5 ± 97.8 vs. 181.2 ± 159.8 days, respectively; $p = 0.04$). Most importantly, and as demonstrated in previous studies, the 1-year mortality rate was lower in the SGLT2i group (1.1% vs. 9.2% in the non-SGLT2i treatment group; $p = 0.009$).</p> <p>Dumortier C, Aho Glele S, Rouland A, et al. Effects of sodium-glucose cotransporter 2 inhibitor use on mortality, amputation, and healing in patients with diabetic foot ulcer. <i>Diabetes Care</i> 2026;49(4):674-681. https://doi.org/10.2337/dc25-2001. PMID: 41739582.</p>
Li <i>et al</i> , <i>Diabetes Care</i>	Meta-analysis	<p>GLP-1 receptor agonists and risk of optic nerve or vision-threatening events in patients with type 2 diabetes or cardiometabolic diseases: a meta-analysis of randomized controlled trials</p> <p>Concerns have been raised in previous studies regarding the link between GLP-1 and ischaemic optic neuropathy, but most of these studies were retrospective. 20 randomised controlled trials with 83,288 participants were included in this meta-analysis, to further study this link. The studies included RCTs involving participants with T2DM, or with overweight /obesity /cardiovascular disease without T2DM, which reported vision-related side effects with GLP-1 compared to another agent/placebo. The results showed no statistically significant increase in the risk of optic nerve or vision-threatening adverse events with the use of GLP-1 among patients with diabetes. Among patient without diabetes, the odds ratio was 0.78 (95% CI 0.27–2.28). Upon testing certain subtypes of GLP-1, no significant adverse events were noted for semaglutide, exenatide, dulaglutide, liraglutide, albiglutide, lixisenatide or efglenatide. Given these findings, the benefits vs risks of using GLP-1 should be assessed for the individual and clinical decisions should be taken accordingly.</p> <p>Li HY, Chan TK, Co Shih K, et al. GLP-1 receptor agonists and risk of optic nerve or vision-threatening events in patients with type 2 diabetes or cardiometabolic diseases: a meta-analysis of randomized controlled trials. <i>Diabetes Care</i> 2026;49(3):526-535. https://doi.org/10.2337/dc25-1929. PMID: 41587563.</p>
Odegaard <i>et al</i> , <i>Diabetes Care</i>	Randomized trial	<p>The effect of substituting water for artificially sweetened beverages on glycaemic and weight measures in people with type 2 diabetes: the Study of Drinks with Artificial Sweeteners (SODAS), a randomized trial</p> <p>Artificial sweeteners are commonly used by individuals with diabetes, but there is no clear scientific evidence regarding their effects on diabetes control. In this trial, 181 participants with type 2 diabetes and habitual intake of artificially sweetened beverages (ASB) were randomized to either continue their intake of ASBs or to substitute that with water for a 24-week period. Participants wore Freestyle Libre sensors for three 14- day periods, they had their bloods checked and weight measured. The results showed that substituting ASBs by water did not improve the weight or the glycaemic end points. From baseline, the HbA1c increased from 7.20% to 7.44% in the water arm, with a mean difference in change of 0.29% (SE 0.12; $p = 0.013$) higher in the water arm compared to the ASB arm. Time in range decreased and time above range increased in both arms, but these findings were not statistically significant. These results are different from the current nutritional recommendations, and replication of the results would be helpful to further shape the understanding of the effects of the ASBs.</p> <p>Odegaard AO, Chang J, Jiang L, et al. The effect of substituting water for artificially sweetened beverages on glycaemic and weight measures in people with type 2 diabetes: the Study of Drinks with Artificial Sweeteners (SODAS), a randomized trial. <i>Diabetes Care</i> 2026;49(2):239-246. https://doi.org/10.2337/dc25-1516. PMID: 41369640; PMCID: PMC12824807.</p>

Authors, Journal	Type of Study	Main results
Mann <i>et al</i> , <i>Diabetes Care</i>	Randomized controlled trial	<p>Impact of oral semaglutide on kidney outcomes in people with type 2 diabetes: results from the SOUL randomized trial</p> <p>The FLOW trial previously established the benefits of GLP1RA in improving kidney and cardiovascular outcomes in a high-kidney-risk population with CKD and diabetes. It tested the use of subcutaneous semaglutide. This paper is from the SOUL trial, which compared oral semaglutide with placebo and showed a 14% reduction in risk of major cardiovascular events. In this part of the study, they tested the effects of semaglutide on kidney outcomes. It included 9,650 patients, 4,825 randomized to either oral semaglutide or placebo. The study showed that oral semaglutide led to a slower rate of eGFR decline compared to placebo (-1.67 vs. -2.06 mL/min/1.73 m²; estimated treatment difference 0.40; 95% CI 0.27, 0.53; p < 0.0001). They also tested the effect of semaglutide on a four-point composite outcome (persistent ≥50% reduction in eGFR from baseline, persistent eGFR <15 mL/min/1.73 m², initiation of long-term KRT (dialysis or kidney transplant)). And a five-point composite outcome which also included death from kidney-related or CV causes. The results did not show statistically significant superiority of semaglutide over placebo in reducing these negative outcomes.</p> <p>Mann JFE, Marx N, Deanfield JE, <i>et al</i>; SOUL Study Group*. Impact of oral semaglutide on kidney outcomes in people with type 2 diabetes: results from the SOUL randomized trial. <i>Diabetes Care</i> 2026;49(2):257-265. https://doi.org/10.2337/dc25-1080. PMID: 41380027; PMCID: PMC12824789.</p>
Snaith <i>et al</i> , <i>Diabetes Care</i>	Randomized controlled trial	<p>Tirzepatide in adults with type 1 diabetes: a phase 2 randomized placebo-controlled clinical trial</p> <p>It has been estimated that two-thirds of adults with type 1 diabetes (T1DM) are overweight or obese, and insulin itself is also associated with weight gain. While tirzepatide has proven benefits in type 2 diabetes, this was a placebo-controlled clinical trial which studied the cardiometabolic effects of tirzepatide in T1DM individuals. The study included 24 participants, aged 18-60 years, with a BMI ≥30 kg/m². A dose of 2.5 mg was given for the first four weeks followed by 5 mg for eight weeks. The mean change in body weight among the tirzepatide group was -10.3kg compared to -0.7kg in the placebo group, with a treatment difference of -8.7 between the two groups (95% CI -12.0 to -5.5 kg; p < 0.0001). Tirzepatide was also associated with a decrease in fat mass, with a treatment difference of -7.2 kg ([95% CI -10.5 to -3.9 kg]; p = 0.0002) compared to placebo. The estimated treatment difference in HbA1c level was -0.4% [95% CI -0.7% to 0.0%]; p = 0.05). There was also a reduction in the insulin dose in the tirzepatide group, with a between-group difference of -35% of baseline total daily insulin dose ([95% CI -47 to -21%]; p = 0.0002). There was no significant difference in fasting lipid levels or blood pressure between the groups. In terms of tolerability, gastro-intestinal side effects were the most commonly reported symptoms, with no major adverse events.</p> <p>Snaith JR, Frampton R, Samocha-Bonet D, Greenfield JR. Tirzepatide in adults with type 1 diabetes: a phase 2 randomized placebo-controlled clinical trial. <i>Diabetes Care</i> 2026;49(1):161-170. https://doi.org/10.2337/dc25-2379. PMID: 41264593; PMCID: PMC12719702.</p>
Jia <i>et al</i> , <i>Diabetes</i>	ELISA assay validation	<p>Identifying insulin autoantibodies with differential risk in type 1 diabetes with a novel bridging ELISA</p> <p>The gold standard for Insulin autoantibody (IAA) detection is radiobinding assay (RBA). A large proportion of islet antibodies, particularly when single antibody positive, are often low affinity and a poor predictor for disease. This novel bridging ELISA can preferentially detect high-affinity IAAs. It eliminates radioactivity seen in RBA and offers a potentially more cost-effective and scalable testing option. Testing was conducted on samples from 227 children newly diagnosed with stage 3 T1DM and positive for at least one islet antibody (using negative islet antibody samples for specificity), showing 99.5% specificity, 65.2% sensitivity compared to 60.8% by RBA. Testing by ELISA on 202 general population children with positive IAA findings by RBA was positive for 80.3% of those with multiple islet autoantibodies and 48.1% of those with single IAA positivity. Samples that were IAA negative by ELISA showed lower antibody affinity. These results require further testing with larger cohorts and parallel RBA testing rather than RBA pre-selection for IAA positivity.</p> <p>Jia X, Zhang C, Waugh K, <i>et al</i>. Identifying insulin autoantibodies with differential risk in type 1 diabetes with a novel bridging ELISA. <i>Diabetes</i> 2026;75(3):519-525. https://doi.org/10.2337/db25-0696. PMID: 41525084; PMCID: PMC12928742.</p>
Keller <i>et al</i> , <i>Diabetes</i>	Prospective cohort study	<p>Dickkopf-3 (DKK3) and the progression of diabetic kidney disease in primary health care</p> <p>Urinary Dickkopf-3 (uDKK3) is a profibrotic tubular protein which correlates with the extent of kidney tissue injury independent of its cause. In this study 3,232 adults with T2DM between 2011 and 2014 treated at the primary care level, were divided into high (n = 406) and low uDKK3 (n = 2826) cohorts and followed up for a median of 4.26 years. High uDKK3 was significantly associated with kidney function decline, independent of baseline eGFR and albuminuria. High uDKK3 was also associated with an increased risk of cardiovascular events and all-cause mortality. uDKK3 may represent a novel tool to personalise T2DM management.</p> <p>Keller F, Schunk S, Denicolò S, <i>et al</i>. Dickkopf-3 (DKK3) and the progression of diabetic kidney disease in primary health care. <i>Diabetes</i> 2026;75(1):144-153. https://doi.org/10.2337/db25-0235. PMID: 41071948; PMCID: PMC12716617.</p>

The Young Diabetologists and Endocrinologists' Forum (YDEF) is a group dedicated to educating, advocating for and supporting Diabetes and Endocrinology (D&E) trainees and doctors who are interested in the specialty across the country.

The field of type 1 diabetes mellitus (T1DM) is rapidly advancing. This is exciting for patients, who now have access to increasingly sophisticated therapies. A particular example is Hybrid Closed-Loop therapy (HCL). The new NHS England 5-year strategy aims to implement this for all NICE-eligible people living with T1DM.

However, education of Diabetes & Endocrinology (D&E) trainees must keep pace to ensure equitable access to training across the UK. Under the 2022 D&E curriculum, all trainees are required to complete training in HCL and diabetes technology prior to completion of training. Despite this, there remains substantial variation in both access to training and implementation of HCL systems across the country. Recent National Diabetes Audit (NDA) data demonstrated that between 10.1% and 27.5% of people with T1DM were using HCL systems by the end of quarter 3 2025/2026 (all age groups), highlighting significant regional variation in uptake.

A particular focus of the YDEF at present is to ensure that trainees have adequate training in diabetes technology and HCL therapy. Although training in diabetes technology, including HCL, is now mandatory within the curriculum, training remains something of a postcode lottery, with some regions having greater exposure to practical experience and access to courses (both free and paid) than others.

In collaboration with Professor Pratik Choudhary, the YDEF has been helping to facilitate a diabetes technology course since 2010. Within the course, the focus is on all things 'Tech', including training on HCL. The primary aim of this course is to provide free expertise from renowned experts in the field to trainees, to give trainees confidence in managing an ever-growing population of people with diabetes with advancing technological management options, and to fulfil mandatory curriculum requirements.

In order to facilitate this and try and meet demands, this hugely popular diabetes technology course now runs twice yearly, usually in July and December. While it is universally offered to trainees at any stage, it is aimed at trainees in their last two years of training (ST6 and ST7) in order to prioritise those who are close to finishing their training. The result is that some trainees do not have access to formal HCL training until

their final years, sometimes being very close to consultancy, due to lack of access. However, trainees across the country will now be confronted with patients living with diabetes using technology from day one of training in ST4.

This year, for the first time, we are introducing a 'Starter technology in diabetes' course aimed at ST4/ST5 trainees, acting as an introductory one-day course in diabetes technology and specifically tailored to the more junior trainee. This will be running in the Autumn of 2026: please keep an eye on the monthly newsletter or website (<https://www.youngdiabetologists.org.uk>). We also continue to offer a brief introduction to some elements of diabetes technology, including access to wearing a continuous glucose monitor, within our ABC of D&E course which usually runs in November/ December of each year.

Despite our best attempts to provide highly educational courses on HCL and diabetes technology, the provision still may not reach everyone. We have brought in new initiatives to ensure that trainees only attend courses once and to reduce non-attendance, which we hope will go some way to ensure that as many people as possible benefit from them. **But we want to hear from you!** Are you interested in setting up a local course on HCL and don't know how to start? Or do you know of good courses available near you that could provide wider benefit? Please contact us (information available on our website below).

All courses are free to SfE members.

Visit our website to become a member of YDEF (which is free!) and see what we have on offer (<https://www.youngdiabetologists.org.uk>).

You can also follow us on X (@youngdiabendo), Linked in (Young Diabetologists & Endocrinologists' Forum) and Instagram!

**Amy Coulden
Diabetes and Endocrinology Registrar,
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YDEF is dedicated to all diabetes and endocrine trainees and is open for new members to register on our website. Take advantage of our regular newsletters and up-to-date advertising of a wide variety of courses and meetings to complement your training. As always, we are continuously looking to develop and propagate our specialty so do not hesitate to contact us if you have any suggestions or questions!



<https://abcd.care/dtn/about-dtn-uk>

The Diabetes Technology Network UK, is an organisation designed to support UK health care professionals who are involved in the delivery of technologies designed to improve the lives of people living with diabetes.

The past six months have been characteristically busy across diabetes technology, with several significant national developments. One of the most notable was last month's launch of the NHS England (NHSE) Technology Dashboard, which for the first time provides transparent, publicly accessible data on how diabetes technology is being rolled out across the country and who is receiving it. If you have not yet explored your local figures, it is well worth visiting the National Diabetes Audit dashboards.

Aware of the challenges that teams were facing around data submission, DTN UK hosted a webinar with NHS England and the National Diabetes Audit team to introduce the dashboard, clarify the rules for data submission, and share practical solutions to common issues. For those unable to attend, a full recording and a transcript of the Q&A session are available on our website.

As we enter the third year of the Hybrid Closed-Loop (HCL) rollout, the combination of this new dashboard and the latest reimbursement allocations sent to integrated care boards (ICBs) means every Trust should now have a clearer picture of local progress and where further focus is needed. NHSE has written to all regional ICBs with funding allocations for 2026/27, and it is essential that all type 1 diabetes (T1DM) services engage in local discussions to understand what funding is available to them.

DTN UK will continue working closely with NHSE to support the HCL rollout through education for both healthcare professionals and people living with T1DM. To support this work, three DTN UK statements have been released since our last update.

The first, authored by Tim Street, addresses the growing use of Large Language Models (LLMs) such as ChatGPT and Grok by both people with diabetes and healthcare professionals. While these tools can assist with tasks such as initial carbohydrate estimation from food images and identifying glucose patterns, DTN UK emphasises that they cannot replace clinical expertise. LLMs must not be used for insulin dosing or personalised medical advice, and users should be aware of their limitations, including the potential for inaccuracies. The statement outlines nine policy recommendations to support the safe and responsible use of AI tools in diabetes care.

The second statement, led by DTN UK Chair Alistair Lumb, provides new guidance on assessing the accuracy of continuous glucose monitoring (CGM) systems. With increasing numbers of devices entering the UK market and no universal standards for CE mark accuracy testing, performance can vary widely. DTN UK recommends prioritising CGM systems that meet eCGM3 criteria or have achieved US FDA Class III pre market approval. Other devices may be used only if they can demonstrate robust, appropriately assessed accuracy—particularly when used in automated insulin delivery systems or by Group 2 vehicle drivers. The statement also acknowledges the excellent work of the Diabetes Specialist Nurse (DSN) Forum, whose regularly updated CGM comparison charts continue to support safe, informed decision making.

Our latest statement, *Roles of industry and clinical teams in onboarding people with type 1 diabetes to hybrid closed loop systems*, responds to concerns raised by industry partners about unsafe onboarding practices. In some cases, industry educators have been asked to train high risk individuals without clinical oversight, without access to pump settings, and without a clear follow up plan. DTN UK stresses that clinical responsibility must always remain with NHS teams. Safe HCL initiation requires clear role boundaries, strong clinical governance, documented care plans and follow up pathways, and close collaboration between NHS teams and industry. Clearly defined responsibilities protect patients, staff and educators, and ensure that onboarding is safe, equitable and consistently delivered. All statements are available in the resources section of our website.

SAVE THE DATE - The DTN UK Annual Meeting will take place on Wednesday 4th November in Solihull, welcoming all healthcare professionals with an interest in diabetes technology. The programme will include workshops, updates from national leaders and a sponsored symposium. Registration IS NOW OPEN and the meeting is expected to be highly popular.

Erica Richardson and the Leicester diabetes team, designed to help services assess the skills within their workforce for managing HCL systems. Building on this work, our committee member Amy Jolly has developed a complementary set of competency and self assessment tools covering both HCL and CGM, intended for use in personal development plans and appraisals. Both resources are due to be published imminently and are set to become valuable additions to the national toolkit for supporting high quality diabetes technology care.

A final reminder to all teams regarding the discontinuation of Levemir: please ensure that people using diabetes technology have been switched to an appropriate alternative basal insulin for emergency use in the event of pump or cannula failure, or during illness.

We also ask clinical teams to work closely with Dexcom UK following the announcement that international manufacturing of the Dexcom G6 sensor will cease. Although no formal end date has been confirmed, teams are advised to begin switching most patients as soon as is practical. This approach will help preserve remaining G6 stock for those who need it most, for example, people using the Ypsopump HCL system. We will share an update as soon as a confirmed date becomes available.

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