A major change to NICE type 2 diabetes guidance

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The past few weeks have been busy with lots of programme planning for the year ahead. The PCDO Society Committee always meets at the start of the year to generate ideas for our National Conference, which will take place on 18–19 November in Birmingham. The programme looks amazing, so don't forget to put the date in your diary; registration is now open. Smaller events are also taking place throughout the year at venues across the country, so please look out for these on our events page.

NICE guidance finally updated

Much of my time over the past week has been spent reading and digesting the long-awaited update to the NICE NG28 type 2 diabetes guideline, published on 18 February – all 124 pages of it!

The evidence rapidly evolves, and comparing agents from different drug classes, and even within a class, is inherently difficult because of variations in trial design, study populations, settings and even prespecified outcomes. It was always going to be interesting to see if the updated guideline specified any agents within a class, and in places it does. Recommendations from NICE are based not only on a systematic review and appraisal of the best available research, but also, and importantly, an assessment of cost-effectiveness. Understanding the context and rationale for the decisions is important, so let's look at the update.

The primary remit for the 2026 update was to focus on medication treatment pathways to reflect the growing evidence that many diabetes treatments do much more than just tackle hyperglycaemia, including offering important cardiorenal risk reduction and protection. An individualised and tailored approach to diabetes care continues to be advocated, with a reminder for us to reinforce diet, healthy living and weight optimisation at every stage. It's good to see reference still being made to diet and healthy living, with signposting to the NHS Better Health website and the NHS Type 2 Diabetes Path to Remission Programme, but there is no new advice with respect to structured education.

The update represents a fundamental shift in the management of type 2 diabetes, with the focus no longer solely on glycaemic control. We are encouraged to make an initial holistic assessment of related comorbidities, including cardiovascular (including heart failure) and renal status, risk of developing cardiovascular disease, weight, age at diagnosis of diabetes and frailty status. Seven treatment paths or "tracks" have been created:

- No relevant comorbidities.
- Obesity.
- Chronic kidney disease.
- Early-onset type 2 diabetes.
- Heart failure.
- Atherosclerotic cardiovascular disease (ASCVD).
- Frailty.

After the initial holistic assessment, NICE encourages us to engage in a shared decision with the person about which comorbidity to prioritise when choosing their medicines, taking particular account of medicines that offer cardiovascular and renal protection, those that are contraindicated and the person's frailty status. Clinicians are signposted to advice on making decisions using NICE guidelines, available here.

So, what are the key take-home messages? First and foremost, in a major change to previous guidance, NICE now recommends that, if glucose-lowering medication is required, SGLT2 inhibitors should be prescribed as first-line treatment, alongside modified-release metformin, to the majority of people with type 2 diabetes, unless contraindicated. Previously, SGLT2 inhibitors were recommended first-line only for those who also had chronic heart failure, established ASCVD or high risk of developing cardiovascular disease.

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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

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A specific pathway for managing frailty has been introduced, which advises us to exercise caution when prescribing SGLT2 inhibitors in those with moderate to severe frailty in whom safety is a concern, reflecting the importance of balancing benefit and risk in vulnerable populations. In such cases, DPP-4 inhibitors should be considered.

Given the increased use of SGLT2 inhibitors, we are also reminded, before initiating this class of medication, to check for previous diabetic ketoacidosis and risk of dehydration or volume depletion, and whether the person is following a very-low-carbohydrate or ketogenic diet. Clear sick day rules are also provided for managing medications during illness.

Earlier use of GLP-1 receptor agonists or tirzepatide is now recommended, but there are restrictions. The most significant change is that NICE now recommends triple first-line therapy, comprising modified-release metformin, an SGLT2 inhibitor and subcutaneous semaglutide (up to 1 mg weekly), in those with established ASCVD. The rationale for using subcutaneous semaglutide 1 mg specifically is: *"greater certainty of clinically important reductions to the person's risk of major adverse cardiovascular events and HbA_{1c} and weight"*, although it should be pointed out that evidence on the benefits of oral semaglutide and tirzepatide was not available at the time of guideline review.

This is the first time we have seen specific recommendations for adults with early-onset type 2 diabetes (defined as that diagnosed before the age of 40 years). These individuals should be offered initial modified-release metformin and an SGLT2 inhibitor, with consideration also given to adding a GLP-1 RA (liraglutide, dulaglutide, or oral or subcutaneous semaglutide) or tirzepatide. This is justified on the grounds of early-onset type 2 diabetes having a more aggressive disease progression, often being associated with obesity and conferring a higher lifetime cardiovascular risk.

Somewhat disappointingly, the same recommendation does not appear in the treatment track for obesity, where consideration for the addition of a GLP-1 RA or tirzepatide is only recommended once a person requires further treatment to reach their individualised glycaemic target after a period of at least 3 months of initial dual therapy with modified-release metformin and an SGLT2 inhibitor. And there I was thinking we had to move away from a glucocentric approach! Individuals hoping to escalate to this drug class earlier for the associated weight loss and cardiovascular benefit will be disappointed, and already I have had difficult conversations with people whose HbA_{1c} is being "too well managed" to be eligible for initiation of these therapies. It is particularly hard when many within this "track" are struggling to access specialist weight management services.

Throughout most of the guidance, SGLT2 inhibitors are referred to as a class; however, for the chronic kidney disease track (which has been simplified compared with the previous guidance), those with an eGFR of 20–30 mL/min/1.73 m^2 should be offered specifically dapagliflozin or empagliflozin, as well as a DPP-4 inhibitor. That said, we are reminded that when more than one medicine from the same drug class is equally suitable for the person, use the least expensive.

The guideline explicitly states that SGLT2 inhibitors and GLP-1 RAs should be used not only for glycaemic control but also for cardiovascular and renal protection. Thus, we should consider continuing them even when people reach their glycaemic or weight targets. We should, however, consider stopping GLP-1 RAs or tirzepatide if a person becomes underweight (BMI <18.5 kg/m^2) or the medication is not helping to reach glycaemic or weight targets and is not being prescribed for cardiovascular benefits.

One unanswered question that remains for me is whether there is a lower BMI threshold for initiating GLP-1 RAs or tirzepatide. For individuals on the obesity track and most of those with early-onset type 2 diabetes, BMI would be high enough that most of us would be comfortable prescribing these agents, but what about those with ASCVD? Not everyone on this track will be obese; in fact, a quick search in my own practice identified that around 25% had a BMI below 27 kg/m^2. I'd be interested to hear your thoughts on this omission in the guidance.

Regarding safety, there are some useful links to MHRA advice with respect to both SGLT2

inhibitors and GLP-1-based therapies. We are also reminded not to prescribe GLP-1 RAs or tirzepatide together with a DPP-4 inhibitor, as these classes have similar mechanisms of action.

In relation to insulin therapy, the benefits of continuing medications that improve cardiorenal outcomes and weight loss is highlighted. Once- or twice-daily basal insulin is recommended as initial insulin therapy. NPH insulin is no longer specified initially, although the guideline states: *"When multiple basal insulin types (including biosimilars) and regimens are equally suitable for the person's needs, use the least expensive option."* Combining basal and short- or rapid-acting insulin (either separate injections or pre-mixed) can also be considered initially, especially if HbA_{1c} is ≥75 mmol/mol.

Glucose targets and monitoring, including continuous glucose monitoring, were not reviewed in this update, and advice remains unchanged.

To save you time, Pam Brown and I have summarised the 124-page document into an At a glance factsheet. Let me know what you think! I suspect many clinicians will fast-track to the 2-page pharmacological treatment pathway or "Visual summary", which can be found in the Tools and resources tab on the NG28 website. For our factsheet, we have also attempted to condense and simplify this with our own single-page summary (*Figure 1*), which you can print for quick reference. Much gratitude to Pam for the many hours she spent on this, and to George Posford for his patience and skill creating this flowchart.

For those of you who are really pushed for time, I can also direct you to our brand-new PCDO Society podcast series. In Episode 1, Julie Lewis and Rahul Mohan discuss the changes to the NG28 guidance.

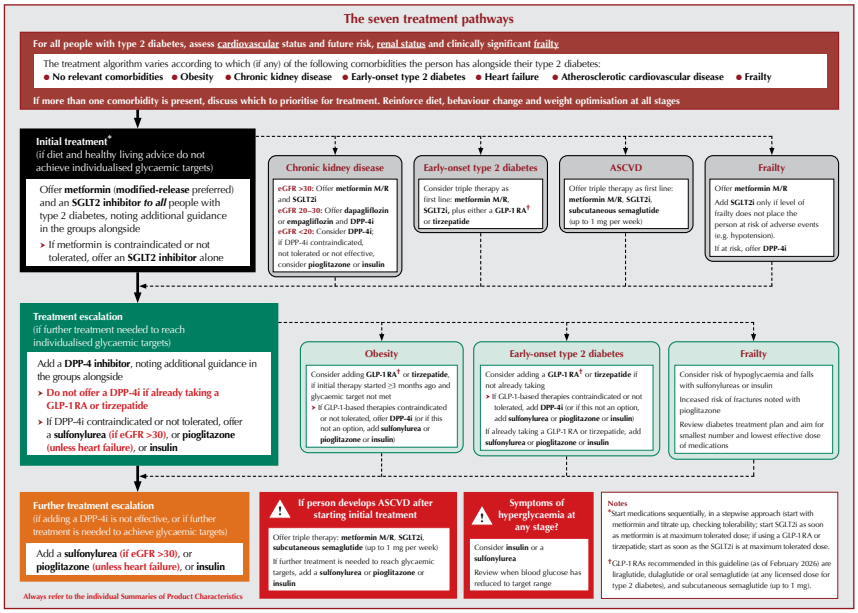

Figure 1. One-page summary of NICE NG28 treatment algorithms. Click to download.

Also in this issue

The Super Six model of diabetes care, implemented in South East Hampshire and Portsmouth in 2011, set out to integrate diabetes management across primary, community and specialist care settings, and was one of the first of its kind. Six key clinical areas remained under the remit of specialist care – inpatient diabetes, antenatal diabetes, diabetic foot care, advanced diabetic nephropathy, insulin pumps and type 1 diabetes (with suboptimal glycaemic control and in young people) – but the model was founded on the principle that not all diabetes care needs to be delivered exclusively within a secondary care/hospital-based setting by specialists.

In 2016, we reported on the five-year evaluation of the Super Six model, which demonstrated measurable improvements in clinical outcomes, reductions in diabetes-related hospital admissions and vascular events, and associated cost savings. In this issue, we share a review of the outcomes 15 years after implementation. While this model continues to demonstrate positive impacts, and has been replicated across the country, the authors highlight the challenges faced by the rising prevalence of diabetes and its increasing complexity, as well as the wider operational pressures facing the NHS.

I do feel there is much to be gained from sharing examples of effective and innovative practice and service delivery, and I would like to remind you of the *Best practice in the delivery of diabetes care in the Primary Care Network* document, published in 2021, which provided guidance on the development of diabetes care delivery within primary care. NHS restructuring is a feature of modern healthcare delivery, purportedly meant to improve care,

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increase efficiency, integrate services, improve collaboration, avoid duplication and, of course (last but not least), control costs. It can be confusing and unsettling to understand and navigate these changes, but care quality has to remain at the heart of a healthcare service. One method to aid this is quality improvement (QI), a systematic, data-driven approach to enhancing the safety, effectiveness, and efficiency of services, particularly in healthcare, by continuously testing and implementing small-scale changes.

Diabetes is a highly complex, heterogeneous disease that presents differently and progresses at varied rates, and one size does not fit all. Not only a person's age but also, perhaps more importantly, their functional status fundamentally affect management, and in this issue Amara Aziz and Garry Tan share a QI project they undertook to explore the appropriateness of glycaemic and blood pressure targets in older adults with type 2 diabetes with moderate to severe frailty. This project was awarded the Roger Gadsby prize recognising an outstanding audit in diabetes primary care at last year's National Conference of the PCDO Society.

Given the complexity of diabetes management and the many complications associated with the condition, there are many related guidelines we need to be aware of. Of particular relevance, of course, is cardiovascular disease. Guidelines are, however, inconsistent about the level of cardiovascular risk that should trigger recommendation of statin therapy. Most of us probably refer to the NICE NG238 guideline, which recommends statin initiation in people with a 10-year predicted risk of cardiovascular disease of 10% or more, although use in those with lower risk is not ruled out if they have made an informed choice or if risk may be underestimated. However, as I have mentioned in previous editorials, statins are often a difficult sell! In *Diabetes Distilled* this issue, we share data which will hopefully help our conversations about statin initiation and persistence, as they show benefits for primary cardiovascular prevention in people living with type 2 diabetes across different levels of baseline risk, with probably a better safety profile than was previously thought.

David Morris's interactive case studies are designed to broaden our understanding of diabetes, and in this issue the focus is on initiating insulin in type 2 diabetes, with two scenarios which encourage us to consider the appropriateness and practicalities of progressing to insulin therapy.

Given the complexity and increasing choice of treatment options for diabetes, shared decision-making is key. The process seeks to empower the person living with the condition to improve their understanding, feel listened to and be encouraged to actively involve themselves in health-related decision-making. Pam Brown reviews and reflects on the importance and impact of shared decision-making in people with type 2 diabetes living with obesity. Of course, not everyone is willing or able to participate in shared decision-making, and Pam discusses why there may be barriers, proposing strategies and tools that may support these conversations to improve obesity care in people with type 2 diabetes. It is a fascinating read and a topic referred to throughout the updated NICE guidance.

Looking at obesity now, our *Prescribing Pearls* series focuses on the use of orlistat for overweight and obesity management. I must confess I can't recall when I last prescribed orlistat, probably because attention has moved on to the incretin therapies. However, the latter agents are not suitable for everyone, and availability may also be a barrier locally. In such cases, orlistat may offer an alternative for some to support weight management.

Our final *Diabetes Distilled* of this issue encourages us to shift the focus of obesity management from purely weight loss to tracking a more holistic view of how obesity impacts the individual in front of us. It offers an integrated framework to assessing obesity that will help reduce stigma and provide a practical tool for improving quality of care, with benefits for both clinicians and people living with the disease of obesity. It is highly thought-provoking, and I trust that Pam's enthusiasm will rub off on all of us! ■