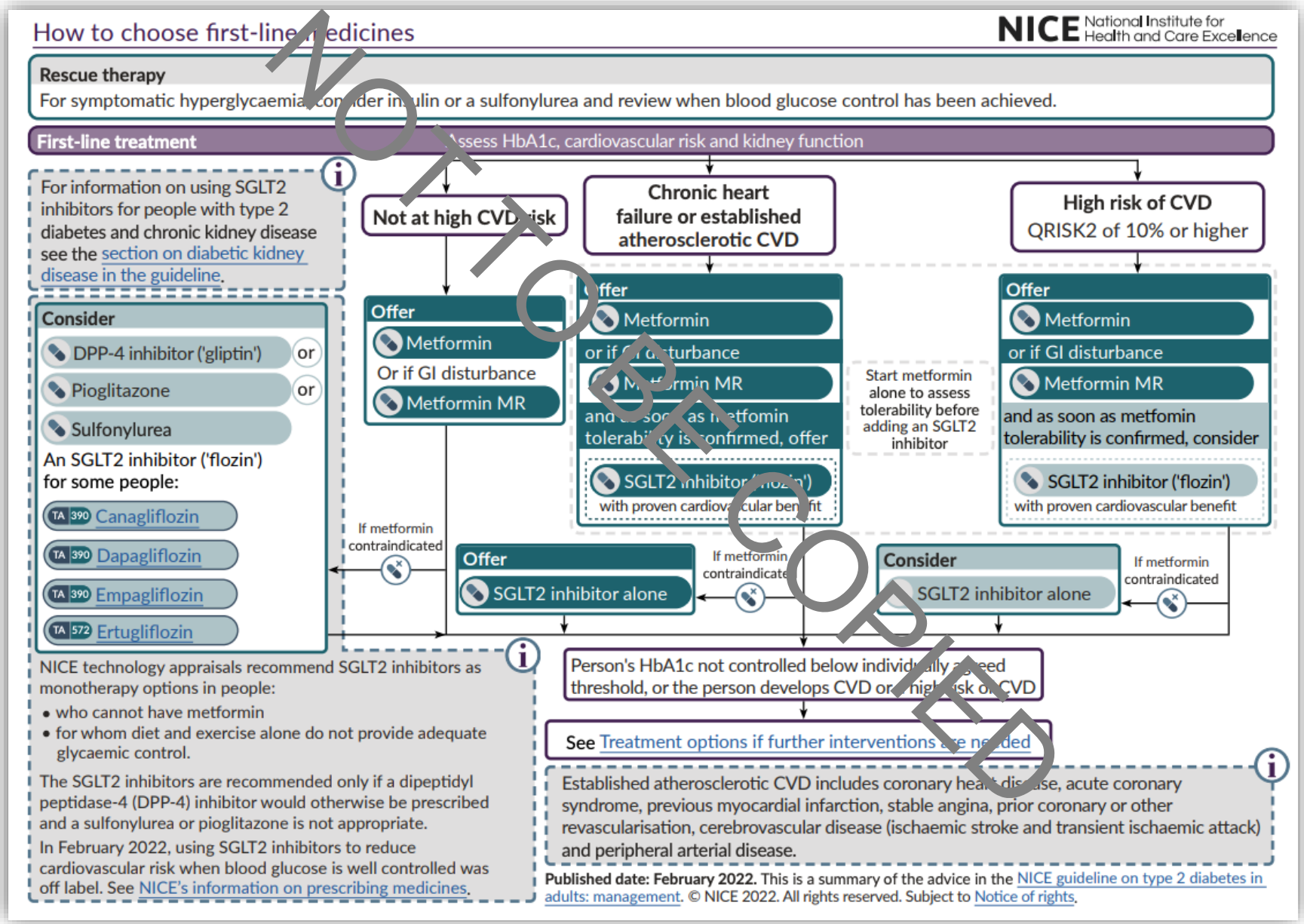
NICE Type 2 Diabetes NG28 Guidelines update 2026

Sarah Davies and Julie Lewis

NICE 2022


How to choose first-line medicines
NICE National Institute for Health and Care Excellence
Rescue therapy
For symptomatic hyperglycaemia consider insulin or a sulfonylurea and review when blood glucose control has been achieved.
First-line treatment
Assess HbA1c, cardiovascular risk and kidney function
For information on using SGLT2 inhibitors for people with type 2 diabetes and chronic kidney disease see the section on diabetic kidney disease in the guideline.
Not at high CVD risk
Chronic heart failure or established atherosclerotic CVD
High risk of CVD
QRISK2 of 10% or higher
Consider
DPP-4 inhibitor ('gliptin') or
Pioglitazone or
Sulfonylurea
An SGLT2 inhibitor ('flozin') for some people:
TA 390 Canagliflozin
TA 390 Dapagliflozin
TA 390 Empagliflozin
TA 572 Ertugliflozin
Offer
Metformin
Or if GI disturbance
Metformin MR
Offer
Metformin
or if GI disturbance
Metformin MR
and as soon as metformin tolerability is confirmed, offer
SGLT2 inhibitor ('flozin') with proven cardiovascular benefit
Start metformin alone to assess tolerability before adding an SGLT2 inhibitor
Offer
Metformin
or if GI disturbance
Metformin MR
and as soon as metformin tolerability is confirmed, consider
SGLT2 inhibitor ('flozin') with proven cardiovascular benefit
If metformin contraindicated
Offer
SGLT2 inhibitor alone
If metformin contraindicated
Consider
SGLT2 inhibitor alone
If metformin contraindicated
NICE technology appraisals recommend SGLT2 inhibitors as monotherapy options in people:
• who cannot have metformin
• for whom diet and exercise alone do not provide adequate glycaemic control.
The SGLT2 inhibitors are recommended only if a dipeptidyl peptidase-4 (DPP-4) inhibitor would otherwise be prescribed and a sulfonylurea or pioglitazone is not appropriate.
In February 2022, using SGLT2 inhibitors to reduce cardiovascular risk when blood glucose is well controlled was off label. See NICE's information on prescribing medicines.
Person's HbA1c not controlled below individually agreed threshold, or the person develops CVD or high risk of CVD
See Treatment options if further interventions are needed
Established atherosclerotic CVD includes coronary heart disease, acute coronary syndrome, previous myocardial infarction, stable angina, prior coronary or other revascularisation, cerebrovascular disease (ischaemic stroke and transient ischaemic attack) and peripheral arterial disease.
Published date: February 2022. This is a summary of the advice in the NICE guideline on type 2 diabetes in adults: management. © NICE 2022. All rights reserved. Subject to Notice of rights.
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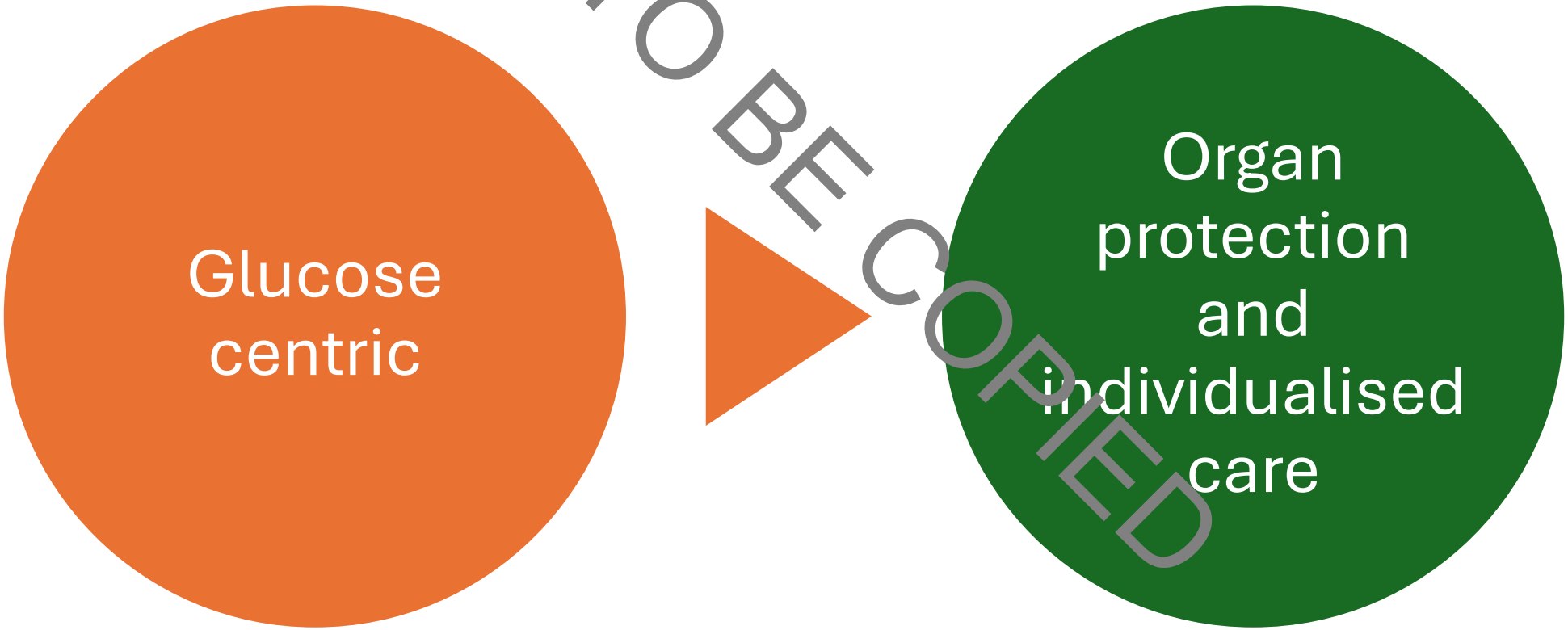
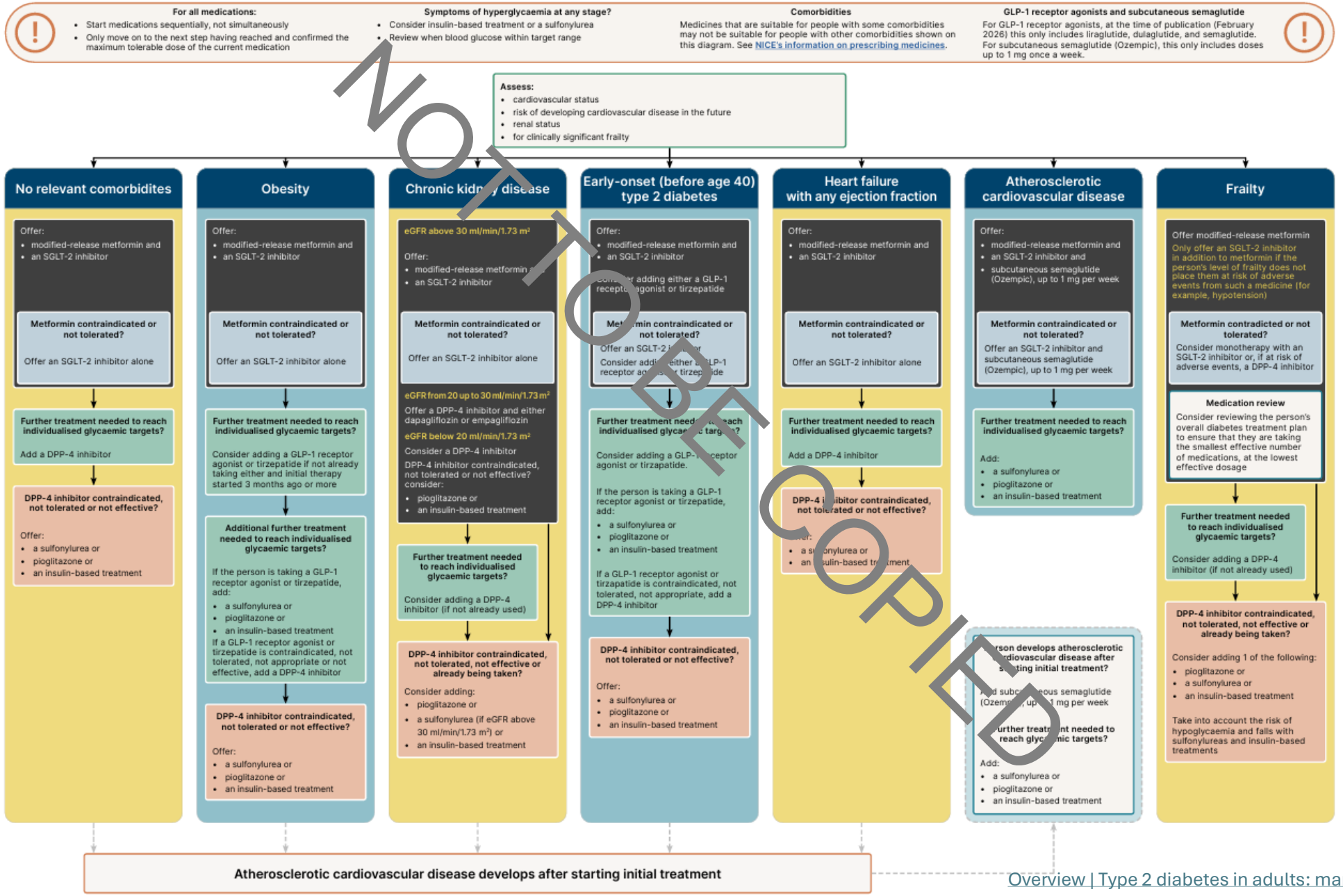
What's new?



NICE 2026



Overview | Type 2 diabetes in adults: management | Guidance | NICE

7 treatment pathways

NICE 2026 G/L key points

- **MR Metformin and SGLT2i for everyone** from diagnosis (unless severe frailty)
  - If metformin not tolerated, SGLT2i alone
- Why modified release metformin?
  - General experience that it is better tolerated and no more expensive than SR
  - No need to switch people who are already happy on standard release
- Symptomatic hyperglycaemia at any stage
  - SU/insulin and review once BG in target range
- What if someone has multiple co-morbidities?
  - “If a person has more than one comorbidity (for example atherosclerotic cardiovascular disease and obesity), make a shared decision with them about which comorbidity to prioritise when choosing medicines.”

Key Points SGLT2is

- Using an SGLT2i very broadly, beyond glycaemic control, for CV/renal protection for almost ALL from a diagnosis of T2DM
  - Why?
    - NICE report significant under use and inequality of use
      - Much less likely to receive one if female, older, black, higher deprivation
      - This G/L aims to simplify and therefore increase access and use

- How quickly should we add the SGLT2i?
  - Introduce the medicines sequentially not simultaneously
  - NICE states “once at max tolerated dose of 1st medication” but also “without delay to ensure people do not remain on metformin alone for prolonged periods”
    - ***I suggest*** 4 weeks where appropriate, give both scripts at first appointment
    - Telephone call at 4 weeks
    - Do I always get max metformin first – nope!

Key Points SGLT2i's - safety

- Broader use = higher risk of AE's including DKA
- NICE make specific recommendations to reduce DKA risk
- Assess whether the person may be at increased risk eg previous DKA, unwell with intercurrent illness, at risk of volume depletion or following low carb/ketogenic diet
  - ***Address any modifiable risk factors***
  - ***I suggest also caution if HBA1c very high, suggest alternative first if HBA1c > 100mmol/mol, caution when > 86mmol/mol***
- We should give and document clear sick day rules advice
  - Resources:
    - Diabetes and being ill | Managing when you're sick | Diabetes UK
    - Type 2 diabetes: What to do when you are ill – Trend Diabetes

Key Points GLP1s

- **Earlier use of GLP1s for many**

- If **obesity (BMI > 30, adjust for ethnicity)** - GLP1/tirzepatide third line after at least 3 months on met/SGLT2i combination and ***HBA1c still above target*** (note using for glycaemic control here not weight alone)

- If **under age of 40** – GLP1/tirzepatide third line and can *consider* using early as *triple therapy* (no need to repeat HBA1c first, no specific BMI criteria)
  - Start one at a time
  - I suggest add every 4 weeks with telephone call at 4 weeks to add SGLT1i, and a f2f at 8 weeks to add GLP1
    - Then HBA1c **3 months later**
    - Aiming for a low Hba1C here < 48mmol/mol

- If **ASCVD** – triple therapy from the get go - met/SGLT2i/semaglutide (sc)
    - Again start sequentially, aim every 4 weeks
    - Sustain-6 CV Outcome trial
    - Tirzepatide not included here as CVOT not included in the analysis

FAQs

- Should we stop a GLP1 once HBA1c is low?
  - NICE suggest *continuing medications that have worked*
    - If no hypo risk or other concerns, no need to stop
  - Shared conversation with the patient
    - Ratify meds as normal
    - Consider down titrating GLP1 for maintenance

- Can we use GLP1s in people of lower BMIs?
  - NICE do not specify a BMI cut off for GLP1s anymore
  - For the majority of use, people will be of a higher BMI eg in obesity and EOT2D but not always
  - Those with ASCVD or some people with T2DM at a lower BMI eg those of South Asian ethnicity
    - Evidence base: BMI > 27
    - Very little evidence base in lower BMIs, consider risks vs benefits eg lean muscle mass, frailty etc

Key Points GLP1s - safety

Medicines & Healthcare products Regulatory Agency

- Consider the risk of worsening retinopathy if HBA1c is high and likely to fall rapidly with treatment
  - Ensure up to date retinopathy screening
  - DESW will screen if HBA1c is high and the person is overdue their DESW appt
  - Pre-GLP1 theory initiation we can refer for free retinal assessments @Optometry

- Pancreatitis risk
  - MHRA Jan 2026: Be alert to the risk of acute pancreatitis. Rare reports of necrotising and fatal pancreatitis.
  - Up until Oct 2025 – 1296 Yellow Card reports, 19 fatal
  - Advise patients to seek urgent medical attention if they develop severe and persistent abdominal pain that may radiate to the back and may be accompanied by nausea and vomiting
  - Caution in people with a history of pancreatitis

Reviewing medications

Reviewing medicines

When reviewing treatments, make a shared decision about changes with the person with type 2 diabetes. See the recommendations on involving people in medicine discussions. Optimise their current treatment regimen before changing treatments, taking into account factors such as:

- adverse effects
- prescribed doses and formulations
- adherence to, and management of, existing medicines
- the need to revisit advice about diet and healthy living.

If response to medicines suggests that type 2 diabetes might not be the correct diagnosis, see the recommendations on initial diagnosis and revisiting initial diagnosis in NICE's guideline on managing type 1 diabetes.

If the person has reached their individualised glycaemic and weight targets (as defined in NICE's guideline on overweight and obesity), consider continuing any medicines that have contributed to this.

Consider continuing SGLT-2 inhibitors for their cardiovascular or renal benefits, even if they do not help the person reach their individualised glycaemic targets.

Stop GLP-1 receptor agonists or tirzepatide if:

- the person becomes underweight (BMI under 18.5 kg/m^2), or
- they do not help the person reach their individualised glycaemic targets and they are not being taken for their cardiovascular benefits.

Do not offer a GLP-1 receptor agonist or tirzepatide and a DPP-4 inhibitor together to treat type 2 diabetes.

- ***Continue*** medications that have contributed to reaching glycaemic and weight targets
- Continue SGLT2i's for CV/renal benefits, even if not helpful for glycaemic targets
- Stop GLP1s if not helping to reach glycaemic targets ***unless the person has CV disease or early onset T2D***
- Stop GLP1s if the person becomes underweight (BMI < 18.5)

Case Studies

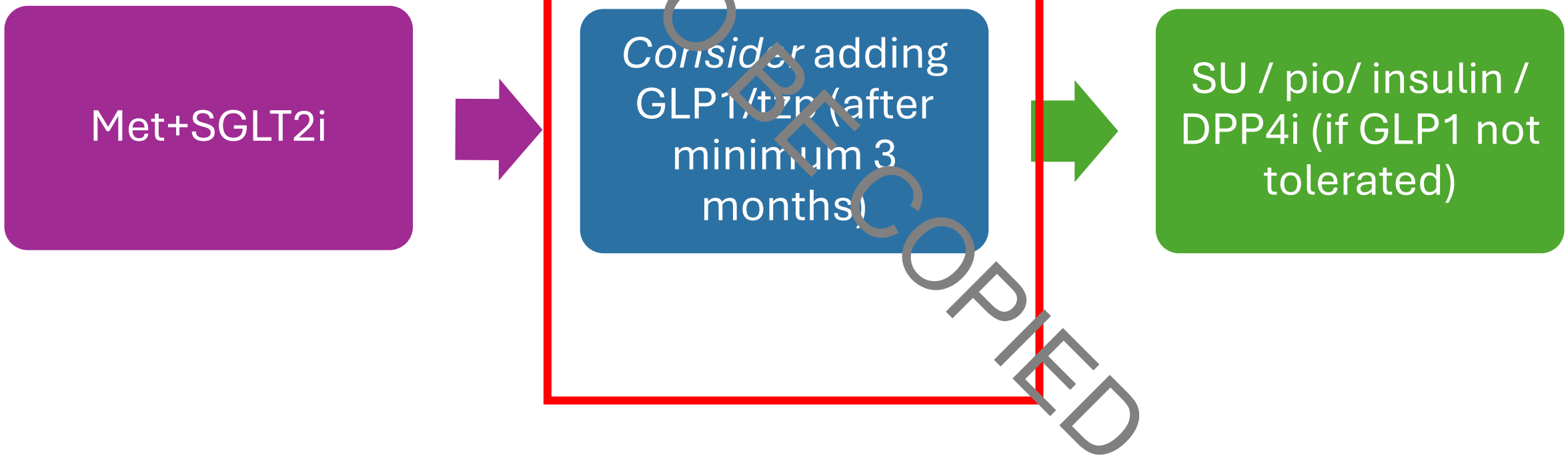
Samantha, 53 year old lady

- PMH: Hypertension
- Meds: Ramipril 10mg
- Newly diagnosed with Type 2 diabetes
- HBA1c 64mmol/mol (repeated and confirmed)
  - eGFR >90, UACR 2.5mg/mmol
  - BMI 32
  - BP 150/84 in clinic
- Works in an office/from home, 2 children at uni, little exercise, struggled with her weight for years.
- Mum died of CVA aged 73

Samantha, 53 year old lady

- Refer for education, signpost to local services
- Discuss remission
- Discuss medications
  - SGLT2i: “Add this medication predominantly to protect your heart and kidneys”
- Keen to proceed, priority for her is to reduce her chance of CV event and prolong life expectancy
  - Start metformin, give script for dapagliflozin
  - Telephone call 4 weeks – getting on fine, adv to start SGLT2i
- Address lipids and BP
- Repeat HBA1c 3 months later
  - HbA1c 55mmol/mol

NICE G/L main co-morbidity: Obesity



Simon, 56 year old man

- Type 2 Diabetes - 3 years
- Angina – diagnosed around 8 years ago
- Medications – metformin 1g bd, empagliflozin 10mg od, aspirin, losartan, bisoprolol, atorvastatin

- Comes for his annual review

- HBA1c 52 mmol/mol
- eGFR 68ml/min, UACR 8mg/mmol
- BMI 29

Atherosclerotic CV disease

Met+SGLT2i+
SC
Semaglutide

HBA1c over target?

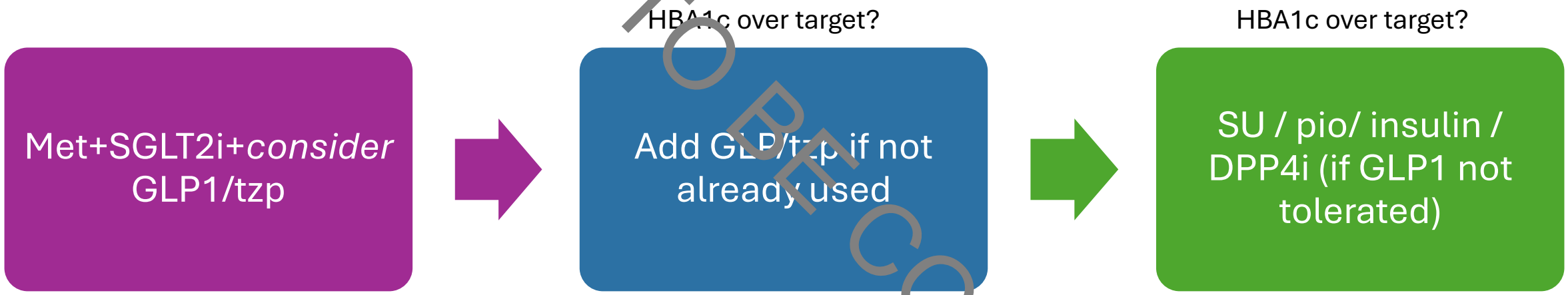
SU / pio/
insulin

Kate, 32 year old lady

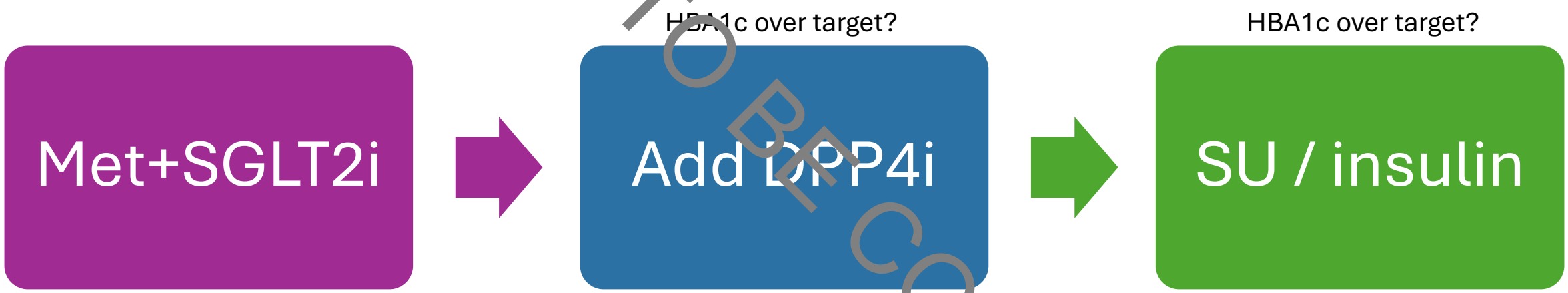
- Newly diagnosed with Type 2 diabetes
  - Presented with recurrent vulvovaginal thrush
  - Hx of GDM x 2
    - Last HBA1c 3 years ago after 2nd delivery 45mmol/mol
- HBA1c 77mmol/mol
- BMI 40

- Really upset, strong FH of T2D
- Busy with two young children, works from home

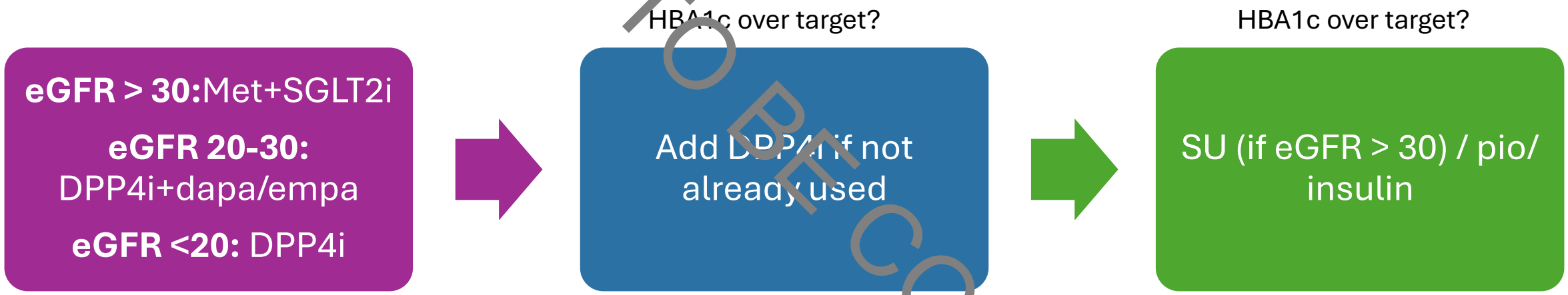
Early Onset Type 2 Diabetes (< 40 years)



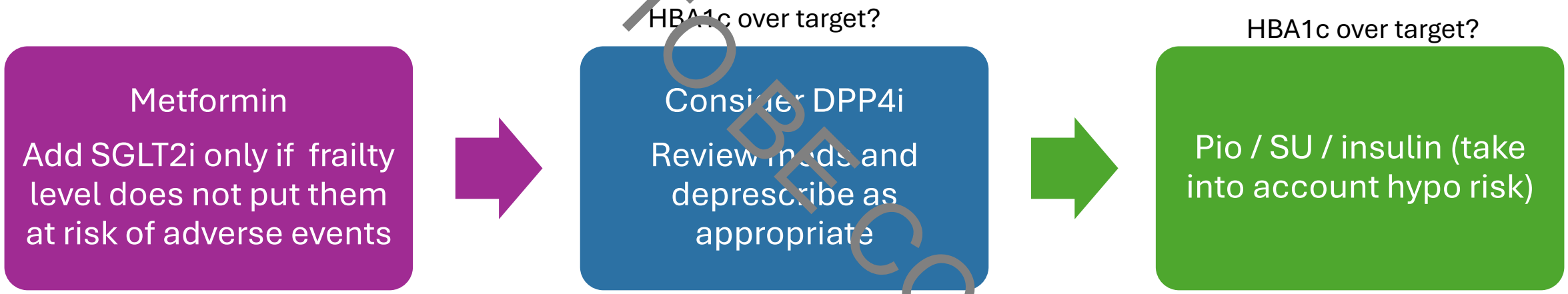
Heart Failure with any ejection fraction



CKD



Frailty



Diabetes and Frailty Guidelines

Patient characteristics	Treatment goal	Recommended targets
Healthy/pre frail/mild frailty	Reverse frailty or limit its progression Maintain functional status, independence, and QoL Prevent or delay macro/microvascular complication	**HbA_{1c} <58 mmol/mol (<7.5%), but ≥42 mmol/mol (≥6%)** FPG 5.0–7.2 mmol/l BP <140/90 mm Hg
Moderate frailty	Prevent decline in QoL Limit the progression of microvascular complications Avoid metabolic emergencies such hypoglycaemia	**HbA_{1c} <64 mmol/mol (<8.0%)** FPG 5.0–8.3 mmol/l BP <140/90 mm Hg
Severe frailty	Improve QoL by reducing symptoms or hospitalisations Maintain functional status, preventing further lower limb dysfunction, preventing significant disability	**HbA_{1c} <69 mmol/mol (<8.5%)** FPG 5.6–10.0 mmol/l BP <150/90 mm Hg

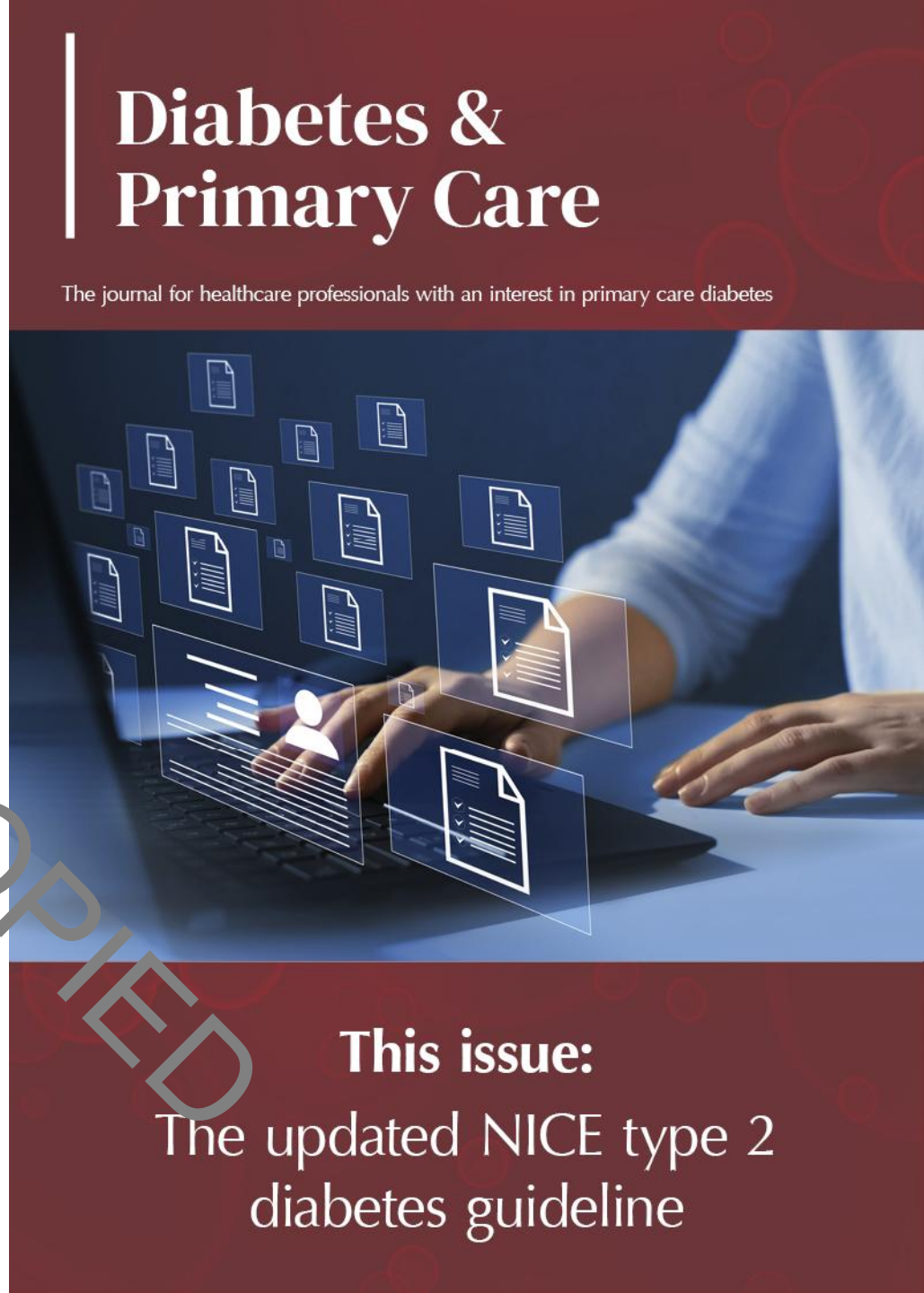
Strain D, Down S, Brown P, Puttanna A et al. Diabetes and Frailty: An Expert Consensus Statement on the Management of Older Adults with Type 2 Diabetes. *Diabetes Ther* 2021

How do we implement these guidelines effectively?

- Will take much time to implement
- Starting QI ideas
    - Search for those with T2D and under age of 40
        - Are they on met/sglt2i/glp1
            - *Consider early review*
    - Type 2 diabetes and ASCVD
        - *Consider early review to offer met/sglt2i/semaglutide*
- Local pathways will take time to catch up!

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

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



The seven treatment pathways

For all people with type 2 diabetes, assess cardiovascular status and future risk, renal status and clinically significant frailty

The treatment algorithm varies according to which (if any) of the following comorbidities the person has alongside their type 2 diabetes:

● **No relevant comorbidities** ● **Obesity** ● **Chronic kidney disease** ● **Early-onset type 2 diabetes** ● **Heart failure** ● **Atherosclerotic cardiovascular disease** ● **Frailty**

If more than one comorbidity is present, discuss which to prioritise for treatment. Reinforce diet, behaviour change and weight optimisation at all stages

Initial treatment*

(if diet and healthy living advice do not achieve individualised glycaemic targets)

Offer **metformin** (**modified-release** preferred) and an **SGLT2 inhibitor *to all*** people with type 2 diabetes, noting additional guidance in the groups alongside

- If metformin is contraindicated or not tolerated, offer an **SGLT2 inhibitor** alone

Chronic kidney disease

eGFR 20–30: Offer **metformin M/R** and **SGLT2i**

eGFR 20–30: Offer **dapagliflozin** or **empagliflozin** and **DPP-4i**

eGFR <20: Consider **DPP-4i** if DPP-4i contraindicated, not tolerated or not effective, consider **pioglitazone** or **insulin**

Early-onset type 2 diabetes

Consider triple therapy as first line: **metformin M/R**, **SGLT2i,** plus either a **GLP-1 RA**† or **tirzepatide**

ASCVD

Offer triple therapy as first line: **metformin M/R**, **SGLT2i**, **subcutaneous semaglutide** (up to 1 mg per week)

Frailty

Offer **metformin M/R**

Add **SGLT2i** only if level of frailty does not place the person at risk of adverse events (e.g. hypotension).

If at risk, offer **DPP-4i**

Treatment escalation

(if further treatment needed to reach individualised glycaemic targets)

Add a **DPP-4 inhibitor**, noting additional guidance in the groups alongside

- **Do not offer a DPP-4i if already taking a GLP-1 RA or tirzepatide**
- If DPP-4i contraindicated or not tolerated, offer a **sulfonylurea (if eGFR >30)**, or **pioglitazone (unless heart failure)**, or **insulin**

Obesity

Consider adding **GLP-1 RA**† or **tirzepatide**, if initial therapy started ≥3 months ago and glycaemic target not met

- If GLP-1-based therapies contraindicated or not tolerated, offer **DPP-4i** (or if this not an option, add **sulfonylurea** or **pioglitazone** or **insulin**)

Early-onset type 2 diabetes

Consider adding a **GLP-1 RA**† or **tirzepatide** if not already taking

- If GLP-1-based therapies contraindicated or not tolerated, add **DPP-4i** (or if this not an option, add **sulfonylurea**, **pioglitazone** or **insulin**)

If already taking GLP-1 RA or tirzepatide, add **sulfonylurea** or **pioglitazone** or **insulin**

Frailty

Consider risk of hypoglycaemia and falls with sulfonylureas or insulin

Inceased risk of fractures noted with pioglitazone

Review diabetes treatment plan and aim for smallest number and lowest effective dose of medications

Further treatment escalation

(if adding a DPP-4i is not effective, or if further treatment is needed to achieve glycaemic targets)

Add a **sulfonylurea (if eGFR >30)**, or **pioglitazone (unless heart failure)**, or **insulin**

⚠ If person develops ASCVD after starting initial treatment

Offer triple therapy: **metformin M/R**, **SGLT2i**, **subcutaneous semaglutide** (up to 1 mg per week)

If further treatment is needed to reach glycaemic targets, add a **sulfonylurea** or **pioglitazone** or **insulin**

⚠ Symptoms of hyperglycaemia at any stage?

Consider **insulin** or a **sulfonylurea**

Review when blood glucose has reduced to target range

Notes

Start medications sequentially, in a stepwise approach (start with metformin and titrate up, checking tolerability; start SGLT2i as soon as metformin is at maximum tolerated dose; if using a GLP-1 RA or tirzepatide, start as soon as the SGLT2i is at maximum tolerated dose.

†GLP-1 RAs recommended in this guideline (as of February 2026) are liraglutide, dulaglutide or oral semaglutide (at any licensed dose for type 2 diabetes), and subcutaneous semaglutide (up to 1 mg).

Always refer to the individual Summaries of Product Characteristics

Thank you! Any Questions?