

Type 2 Diabetes

Consultation on draft guideline - Stakeholder comments table 19/08/2025 – 02/10/2025

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A. Menarini Farmaceutica Internazionale SRL	Consultation questions		001	(Q1) Would it be challenging to implement any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives). It is important to support the autonomy of the prescribing healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer [NICE Guidelines Manual]. Excluding canagliflozin from NG28 guidance regarding patients with T2D and CKD may be challenging as it reduces autonomy of prescribing HCPs to recommend the SGLT2i they think is most appropriate for their individual patients. Particularly in primary care patients already established on treatment with canagliflozin.	Thank you for your comment. Your feedback will be considered by NICE where relevant implementation support activity is being planned. Additionally, there is now a recommendation for offering any SGLT-2 inhibitor for those with an eGFR >30 ml/min/1.73²
A. Menarini Farmaceutica Internazionale SRL	Consultation questions		002	(Q2) Would implementation of any of the draft recommendations have significant cost implications?	Thank you for your comment.

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				Menarini does not believe that there are any significant cost implications in including canagliflozin on the guideline	
A. Menarini Farmaceutica Internazionale SRL	Consultation questions		003	(Q3) Should NICE update the existing technology appraisals for canagliflozin, dapagliflozin, empagliflozin, and ertugliflozin (TA288, TA315, TA336, TA390, TA418, TA572, TA583)? If so, please provide a rationale for this. Details of the update process are in NICE health technology evaluations: the manual, see 8.4 Surveillance decision options. Menarini does not believe an update to existing technology appraisals is necessary.	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.
A. Menarini Farmaceutica Internazionale SRL	Visual summary	002	Chronic kidney disease	In line with previous comments 1 and 2 about the NICE "Guideline" document, canagliflozin should be included with dapagliflozin and empagliflozin as a suitable SGLT2-inhibitor option in the management of T2D and CKD in adults. [i.e., canagliflozin should appear in the high-level section "eGFR above 30 ml/min/1.73 m ² " as well as in the pale blue box panel "Metformin contraindicated or not tolerated?"]	Thank you for your comment. There is now a recommendation for offering any SGLT-2 inhibitor for those with an eGFR above 30 ml/min/1.73 ² . The recommendations in the visual summary have been amended following these changes

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A. Menarini Farmaceutic a Internazionale SRL	Visual summary	002	Chronic kidney disease	There is no mention of urinary ACR result - only eGFR is stated. A confirmed urine ACR of 3 mg/mmol or more, is a key part of the CKD diagnosis in the CKD NICE guidelines and should be included. Using one of the three SGLT-2 inhibitors with proven renal benefit for people with T2D is important. Canagliflozin should be included in the management of T2D and CKD in adults, as well as dapagliflozin and empagliflozin. Please refer to previous comments 1 and 2.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. Recommendations about urinary ACR are included in NICE's guideline about chronic kidney disease and there is cross reference to this in the visual summary. There is now a recommendation for offering any SGLT-2 inhibitor for those with an eGFR >30 ml/min/1.73 ² . The recommendations in the visual summary have been amended following these changes
A. Menarini Farmaceutic a Internazionale SRL	Guideline	018	004	1.8.9 People with type 2 diabetes and no significant comorbidity Should a lower BMI [body mass index] threshold be specified when referring to addition of a SGLT-2 inhibitor, to help ensure potential insulinopenic patients with lower BMIs are not routinely prescribed SGLT-2 inhibitors?	Thank you for your comment. The committee did not make a recommendation based on this. On considering weight loss due to SGLT-2 inhibitors, the committee agreed that this was likely associated with fluid loss due to excretion by urine as a part of the mechanism of action of SGLT-2 inhibitors. Therefore, unlike with GLP-1 receptor agonists where an additional recommendation has been made in this scenario, they did not agree that an adjustment to a recommendation was necessary. Healthcare professionals should always consider the benefits and risks of treatments for each person on a case by case basis and whether a treatment is appropriate for them.
A. Menarini Farmaceutic a	Guideline	020	004	<u>1.8.18</u> People with early onset type 2 diabetes	Thank you for your comment. For people who do not have chronic kidney disease (where there are reasons stated in the summary of product characteristics that mean that specific

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Internazionale SRL				Specific SGLT-2 inhibitors are currently listed in the CKD section. In early-onset type 2 diabetes is it appropriate to state the SGLT-2 inhibitor with greatest HbA1c and weight efficacy based on evidence. Canagliflozin 100mg, increasing to 300mg if eGFR remains >60mL/min/1.73m². NICE has always recommended using the medication within the class which is the most effective for the individual and canagliflozin meets the criteria for this group. Canagliflozin has a place with early-onset type 2 diabetes and working-aged people with an eGFR >30 and an ACR > 3, ensuring best HbA1c reduction efficacy in class. This remains important with young adults with type 2 diabetes, and should not be excluded from the guideline. NG28 is a T2D management document and not CKD in the general population. This also fits with 1.8.39 of the guidance – line 20. 1. Zaccardi F, et al. (2017). Efficacy and safety of sodium-glucose co-transporter-2 inhibitors in type 2 diabetes mellitus: systematic review and network meta-analysis, Diabetes Obesity and	SGLT-2 inhibitors should not be used) there is no reason based on clinical effectiveness that one SGLT-2 inhibitor should be prioritised over another. They all were of relative clinical effectiveness. When examining cost effectiveness, they were all examined as a class. Therefore, they were recommended as a class.

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				Metabolism, 2016 ;18(8):783-94. https://doi.org/10.1111/dom.12670 2. Gogorjo-Martinez et al. (2023). Effectiveness and tolerability of the intensification of canagliflozin dose from 100 mg to 300 mg daily in patients with type 2 diabetes in real life: The INTENSIFY Study, Journal of Clinical Medicine, 2023;12(13):4248. https://doi.org/10.3390/jcm12134248	
A. Menarini Farmaceutica Internazionale SRL	Guideline	021	010	1.8.24: People with chronic kidney disease CURRENT WORDING: For adults with type 2 diabetes and an estimated glomerular filtration rate (eGFR) above 30ml/min/1.73m²: • Offer metformin and either dapagliflozin or empagliflozin. • If metformin is contraindicated or not tolerated, offer either dapagliflozin or empagliflozin alone. [2025] WORDING FOR CONSIDERATION: • Offer metformin and canagliflozin, dapagliflozin, or empagliflozin	Thank you for your comment. CANVAS and CREDENCE trials were included in this review however CAMPIONE was excluded based on the comparator used in the trial (stated as guideline standard of care only). The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .

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				- If metformin is contraindicated or not tolerated, offer canagliflozin, dapagliflozin or empagliflozin OR - adopt neutral class-level wording that includes canagliflozin as an option alongside other SGLT2 inhibitors when clinically appropriate and licensed, with patient-specific selection based on clinical judgement, comorbidities and preferences. RATIONALE: - Canagliflozin 100mg is licensed for treatment of CKD in patients with type 2 diabetes (T2D) and eGFR >30 mL/min/1.73 m², increasing the dose to 300mg in appropriate patients with eGFR >60 mL/min/1.73 m², as an add on to standard of care (e.g., ACE-inhibitors or ARBs). [Invokana SmPC; Invokana EPAR 2020]. - Section 1.5.6.1 of the draft NICE <i>Committee Discussion</i> document outlines the cardio-renal benefits identified in its network meta-analysis with canagliflozin having the “greatest number of outcomes showing benefits when compared to placebo with reductions in event rate for 3-	

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				item MACE, hospitalisation for heart failure and end-stage kidney failure”. - Individual preferences: excluding canagliflozin may override the autonomy of prescribing HCPs to make decisions for individual patients, based on the needs of the individual patient. - The clinical benefits of canagliflozin in T2D patients with CKD have been demonstrated in two major CV outcome trials: The CREDENCE study assessed the effects of canagliflozin 100 mg compared with placebo on clinically important renal outcomes in people with T2D and established CKD (eGFR 30 to <90 mL/min/1.73 m²) and albuminuria (ratio of albumin to creatinine >300 to 5000 mg/g). Canagliflozin significantly reduced the rates of the composite outcome of ESKD, doubling of serum creatinine, or renal or CV death (43.2 and 61.2 per 1000 PY in the canagliflozin and placebo arms, respectively), resulting in a 30% relative risk reduction (HR, 0.70; 95% CI, 0.59–0.82; P=0.00001; number needed to treat = 22 over 2.5 years for the primary composite endpoint) [1].	

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				In the CANVAS Program, canagliflozin was compared with placebo on clinically important cardiovascular (CV) and renal outcomes in people with T2D at elevated CV risk. 20% had moderately impaired renal function with a mean eGFR 77 mL/min/1.73 m²) with baseline renal function normal or mildly impaired in 80% patients. For time to first adjudicated nephropathy event (doubling of serum creatinine, need for renal-replacement therapy, and renal death), the HR was 0.53 (95% CI: 0.33, 0.84) for canagliflozin (0.15 events per 100 patient-years) versus placebo (0.28 events per 100 patient-years). In addition, canagliflozin reduced progression of albuminuria by 25.8% versus placebo 29.2% (HR: 0.73; 95% CI: 0.67, 0.79) in patients with baseline normo- or micro-albuminuria [2]. In addition to the CV outcome trials the CANPIONE (early CKD with microalbuminuria) study showed a 30.8% greater reduction in UACR vs control and meaningfully slowed the within-individual chronic eGFR decline (between-group difference in slope change +4.4 mL/min/1.73 m²/yr, 95% CI 1.6–7.3). This fills an evidence gap for earlier CKD [3].	

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				A recently conducted network meta-analysis (NMA) of 30 RCTs concluded that canagliflozin was shown to exert the greatest therapeutic effect in terms of reducing the risk of renal impairment compared with other SGLT2is [4]. Another recently published NMA that studied dose-dependent renoprotection of SGLT2is in T2DM reported the highest surface under the cumulative ranking curve (SUCRA) probability score for both canagliflozin doses, 100mg and 300mg, compared with other SGLT2is [5]. 1. Neal B, et al. (2017). Canagliflozin and Cardiovascular and Renal Events in Type 2 Diabetes. N Engl J Med; 377(7):644-57. 2. Perkovic V et al. (2019). Canagliflozin and Renal Outcomes in Type 2 Diabetes and Nephropathy. N Engl J Med;380:2295-306 3. Miyamoto et al. (2024). 4. A randomized, open-label, clinical trial examined the effects of canagliflozin on albuminuria and eGFR decline using an individual pre-intervention eGFR slope. Kidney International, Volume 106, Issue 5, 972 – 984.	

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				5. Ma, J., Lu, J., Shen, P., Zhao, X. and Zhu, H. (2023). Comparative efficacy and safety of sodium-glucose cotransporter 2 inhibitors for renal outcomes in patients with type 2 diabetes mellitus: a systematic review and network meta-analysis. Renal Failure, [online] 45(2), p.2222847 6. Hegde, N.C., Kumar, A., Patil, A.N., et al. (2023). Dose-dependent renoprotection efficacy of sglt2 inhibitors in type 2 diabetes: systematic review and network meta-analysis. Acta Diabetologica, [online] 60(10), pp.1311–1331	
A. Menarini Farmaceutica Internazionale SRL	Guideline	025	005	1.8.40 For adults with type 2 diabetes who are taking standard-release metformin Can clarifying wording be added to the statement: “if it is not tolerated, offer modified-release metformin” so it reads: “if it is not tolerated, or if there is poor adherence to twice-daily standard metformin, offer modified-release metformin” [or similar wording]. (This appears elsewhere on the algorithm and in the guidelines, but would simplify the message if also included here).	Thank you for your comment. Following committee discussion, the committee agreed that modified release metformin would have better tolerance and subsequent adherence than standard-release metformin. Therefore, the recommendations have been updated to recommend modified-release metformin as first line for all people prescribed metformin.

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A. Menarini Farmaceutica Internazionale SRL	Guideline	029	011	1.8.54 Clarity on definition of 'obesity' would be useful for training purposes. Do you mean BMI >30 (in line with SIGN guidelines). How would this be reduced for ethnic groups? [The NHS website on obesity states: Asian, Chinese, Middle Eastern, Black African or African-Caribbean family background you'll need to use a lower BMI score to measure overweight and obesity].	Thank you for your comment. The guideline now has cross references to the definitions used in the overweight and obesity management guideline to clarify this.
Amgen UK	Guideline	General		Amgen welcomes the opportunity to respond to the draft update of the NICE guideline on the management of Type 2 diabetes in adults. We commend the committee for its robust, evidence-led approach, and for recognising the central role of cardiometabolic risk and obesity in shaping modern diabetes care. We strongly support the guideline's emphasis on individualised treatment — including the importance of tailoring care to comorbidities, lifestyle, and personal preferences — and its alignment with real-world priorities such as long-term adherence, health equity, and shared decision-making. We are particularly pleased to see the prioritisation of agents with demonstrated cardiovascular	Thank you for your comment. The committee considered any treatment for diabetes that was licensed for use in the UK at the time that the review started. The primary aim of the guideline is to support people with diabetes with cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this.

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				benefits, as shown in placebo-controlled cardiovascular outcomes trials (CVOTs) with statistically significant reductions in major adverse cardiovascular events. These recommendations align with international consensus and will help ensure that people living with Type 2 diabetes and elevated cardiovascular risk are offered therapies that improve not only glycemic control, but also long-term survival and quality of life. We believe that the guidance could go further in recommending agents with proven efficacy in weight loss or that have a license for weight management given the undeniable relationship between obesity and type 2 diabetes. The cardiometabolic risk reduction added to the glycemic and weight improvements should be considered front line in a patient centric guideline. However, we believe there is further opportunity for NICE to support innovation in real-world care delivery by more explicitly acknowledging the clinical and operational value of treatments that will offer simplified, less frequent dosing. New agents that allow for monthly or longer-interval administration may significantly reduce the burden of diabetes management for both patients and healthcare professionals — especially in primary	

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				care, where capacity and continuity are under increasing pressure. We encourage the guidelines to recognise that ease of use, administration frequency, and overall treatment burden are meaningful factors in both real-world effectiveness and health system efficiency. Extended-interval therapies can: • Reduce the need for frequent clinical contact and supervision • Improve persistence and adherence in younger or underserved populations • Align with evolving models of care such as pharmacy-led clinics and digital monitoring • Minimise friction points in the patient experience (e.g., injection fatigue, daily routine disruption) We also support the committee's recognition of health inequalities in diabetes care and urge continued attention to equitable access — including how simplified, long-acting treatment options may reduce barriers to initiation and persistence among groups historically underrepresented in outcomes data.	

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				Lastly, we encourage NICE to explore how digital tools and predictive analytics could support implementation of these guidelines. Innovations in virtual coaching, remote monitoring, and AI-enabled risk stratification may help scale diabetes services sustainably, particularly as newer therapies come to market. In summary, Amgen supports the direction of the draft guideline and welcomes its emphasis on cardiometabolic outcomes, evidence-based risk reduction, and individualised care. We urge the committee to further recognise the value of simplified and less burdensome treatment strategies, in addition to those agents that have shown significant weight reduction which will be critical to ensuring future innovations translate into meaningful improvements in both patient and system-level outcomes.	
Aneurin Bevan University Health Board	Guideline	General		No mention of the use of GLP-1 analogues (s.c semaglutide) in the treatment pathway for patients with T2DM and CKD. GLP-1s are seen as one of the four pillars of CKD treatment.	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal and cardiovascular protection for people with CKD, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be

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Aneurin Bevan University Health Board	Guideline	General		There is no mention of any BMI cut off or guidance on suitable BMI to offer s.c semaglutide as part of the triple therapy in patients with ASCVD	Thank you for your comment. We recognise that this is an area that has caused some concern. In this guideline, subcutaneous semaglutide is being offered primarily for cardiovascular and renal protection. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. Therefore, the committee agreed that there is no BMI cut off or target for when it should be used. A recommendation has been added to state that it should be stopped if someone becomes underweight.
Aneurin Bevan University Health Board	Guideline	General		No mention of guidance on deprescribing treatments for patients when their HbA1c has been lowered into the non-diabetic range < 42mmol/mol,	Thank you for your comment. In the committee's experience, when some people have their medications stopped after they reach their glycaemic targets, it

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				especially those that are on SGLT2i/GLP-1 for cardiorenal benefits.	can lead to their HbA1c levels rising again. The recommendation for stopping GLP-1 receptor agonists or tirzepatide has been updated with reference to individualised glycaemic control. The committee did not make specific glycaemic control targets as they agreed these can be arbitrary but specified the importance of individualised glycaemic targets (recommendation 1.8.42). SGLT-2 inhibitors are a good treatment option for most people and provide cardiorenal protection that cannot be measured by tests. Therefore, the committee agreed that these should be continued even if they do not help the person reach their glycaemic and weight targets. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Aneurin Bevan University Health Board	Guideline and Evidence reviews	General		New licensed maximum dose for subcutaneous semaglutide is 2 mg once a week for T2DM however no 2 mg pen marketed or due to be marketed in the UK. This means 2 x 1 mg pens is	Thank you for your comment. A clarification has been added that subcutaneous semaglutide (Ozempic), up to 1 mg once a week should be offered (this excludes the new 2 mg dose of

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Aneurin Bevan University Health Board	Guideline	010	024-029	We would like to ask if there is going to be guidance on Frailty adjusted glycaemic targets in patients > 65 years and frailty syndromes to assist GPs/ HCPs. If Panel are in agreement, previously suggested HbA1c targets are : CFS 1-4 53-59 mmol/mol CFS 5-6 59-64 mmol/mol CFS 7,8 64 mmol/mol -69 mmol/mol CFS 9 symptom control [5] Strain WD, Down S, Brown P, Puttanna A, Sinclair A. Diabetes and Frailty: An Expert Consensus Statement on the Management of Older Adults with Type 2 Diabetes. Diabetes Ther. 2021 May;12(5):1227-1247 If not, we would recommend guidance on target setting according to Frailty level is included.	Thank you for your comment. The committee agreed that these targets should be individualised. This is discussed in the recommendations after this that mention NICE's patient decision aid on type 2 diabetes: agreeing someone's blood glucose (HbA1c) target. This has been reinforced later in the guideline when discussing reviewing medicines to make this clearer. The committee does not want to set values for HbA1c as they do not have evidence to support this and do not believe this will be the best for care. The patient decision aid related to the guideline is available to support this.
Association of British Clinical	Visual summary			With the publication of the SURPASS CVOT data, please consider if tirzepatide needs to be added to the ASCVD pathway (although it is no better than	Thank you for your comment. We could not assess the SURPASS-CVOT trial, as we did not receive sufficient evidence to support assessment of the clinical effectiveness of tirzepatide. Therefore, we cannot state that tirzepatide has

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Association of British Clinical Diabetologists	Visual summary			In the obesity pathway, why only use a GLP-1? With the data from SURPASS 2, why not also consider tirzepatide given its superior efficacy in glycaemic control and weight reduction?	Thank you for your comment. The term in the guideline has changed to "GLP-1 receptor agonist or tirzepatide" in order to capture the place for tirzepatide in the guideline.
Association of British Clinical Diabetologists	Guideline	021	010	While the recommendation to start patients with Diabetes and CKD on Dapagliflozin and Empagliflozin is welcome, we wonder why the Canagliflozin has not been recommended. In addition to Empagliflozin, only Canagliflozin has been shown to have a beneficial effect on 3-point MACE as shown in the CANVAS study, and as such the omission of canagliflozin seems to be an error. Similarly, CREDENCE trial strongly supports the use of Canagliflozin in patients with diabetes and CKD with over proteinuria and therefore should be considered.	Thank you for your comment. The CANVAS and CREDENCE trials were included in this review. The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .
Association of British	Guideline	027	002	With the tirzepatide SUMMIT trial, why not include tirzepatide in those with HFpEF?	Thank you for your comment. The SUMMIT trial includes people with heart failure living with obesity who don't

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Clinical Diabetologists					necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update.
Association of British Clinical Diabetologists	Guideline	028	004	With the publication of the SURPASS CVOT data, please consider if tirzepatide needs to be added to the ASCVD pathway (although it is no better than dulaglutide, but has superior weight loss and glucose efficacy)	Thank you for your comment. While we have seen the initial findings from the SURPASS CVOT trial, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection while GLP-1 receptor agonists included in the review have shown this and subcutaneous semaglutide has shown this and cost-effectiveness, therefore being recommended. Any relevant studies such as the SURPASS-CVOT trial published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline
Association of British Clinical Diabetologists	Guideline	031	001	We welcome the recommendation in relation to the use of SGLT2i in patients with CKD. It is surprising that despite the definitive RCT demonstrating benefit of Semaglutide in diabetes patients with CKD it is not recommended in the draft guideline for CKD. With the data from the FLOW trial, showing renal benefit of semaglutide, that needs to be added to the CKD pathway. (and page 82 lines 28). This would also align with other international guidelines. Eg KDIGO which recommend use of	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if

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				GLP-1 RA as the next preferred glucose lowering agent in CKD.	they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Association of British Clinical Diabetologists	Guideline	031	003	Should this not say eGFR appropriate dose?	Thank you for your comment. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Association of British Clinical Diabetologists	Guideline	032	020	If someone has a high HbA1c and I add insulin, I will often not stop the oral agents – e.g. pio, or the SU, only if I feel there is an added risk of hypoglycaemia.	Thank you for your comment. The committee highlight the risk that sulfonylureas and insulin based treatments have in causing hypoglycaemia and falls. For this population, the committee consider it important that the smallest effective number of treatments are being used at the lowest effective dose to reduce the impact on their quality of life. However, the therapy for each person should be considered on a case-by-case basis.
Association of British Clinical Diabetologists	Guideline	034	017	No suggestion / recommendation for Fixed Dose combination of GLP- 1 and long acting insulin?	Thank you for your comment. Further information around fixed dose combinations of insulin degludec and liraglutide is provided in the link to the MHRA's guidance on minimising the risk of medication error with high strength, fixed combination and biosimilar insulin products.

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Association of British Clinical Diabetologists	Guideline	036	005	The gastroparesis section needs to consider having comments about perioperative diabetes care – in particular that where possible, shared decision making about stopping the drug should be made between the anaesthetist and patient, and that in general, GLP-1 agents should not be stopped, and SGLT2 inhibitors should be stopped the day before a procedure – in line with CPOC guidance (Perioperative Care of People with Diabetes Undergoing Surgery Centre for Perioperative Care). That if gastroparesis is suspected that mitigation strategies should be used – e.g. off label preoperative low dose (0.5mg/kg) IV erythromycin, point of care gastric ultrasound and anaesthetic techniques to reduce the risk of pulmonary aspiration.	Thank you for your comment. The gastroparesis section of the guideline is out of scope for this update, and so we are unable to make changes to these recommendations.
Association of British Clinical Diabetologists	Guideline	052	002	Now that dapagliflozin is generic, with comparable CVOT / HF / CKD data to empagliflozin, will the 'lowest acquisition cost' clause be reinserted?	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so

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					other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
Association of British Clinical Diabetologists	Guideline	057	005	Previous NICE guidance has often said 'agent with the cheapest acquisition cost' – here for GLP-1's, with CVOT data, it is likely to be generic liraglutide. Are NICE saying do not use this, but semaglutide or tirzepatide? (mentioned on page 80 line 22). This needs clarification.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise

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					specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
Association of British Clinical Diabetologists	Guideline	083	012	With the epidemiologically increased risk of distal forearm fractures in pio users (e.g. Pioglitazone and Risk for Bone Fracture: Safety Data From a Randomized Clinical Trial - PMC), should it be recommended in those with frailty?	Thank you for your comment and the link to the study. Pioglitazone has been recommended as an option in situations where initial treatments have not been sufficient to achieve glycaemic control or where they are contraindicated or not tolerated. As information on fracture risk is known and covered in the drug's SPC, the committee decided this did not need to be stated in a recommendation. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).

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Association of British Clinical Diabetologists	Guideline	084	021	BNF prices states that branded lantus is 30% cheaper than abasaglar, so this statement is currently incorrect?	Thank you for your comment. This section was out of scope as it is a historical reference to the previous recommendations. However, the statement is still appropriate as it states that if a biosimilar is available, then (the medicine) with the lowest cost should be used. If that is not the biosimilar, then the branded formulation can be used. Therefore, this does not need to be edited to maintain the meaning of the recommendation.
AstraZeneca	Consultation questions		001	Concern In response to question 1 (would it be challenging to implement any of the draft recommendations?), AstraZeneca has concerns on the implementation of recommendation 1.8.34, which states that when an adult with T2D start initial therapy with metformin and one or more other medicines: • 'Introduce the medicines one at a time, starting with metformin and checking tolerability' According to the SGLT2 inhibitor uptake report, the percentage of patients with T2D in primary care with a current prescription for an SGLT2 inhibitor in September 2023 was relatively low.[2] The report stated that, despite the February 2022 NICE guideline recommendations, the percentage of patients with a prescription for an SGLT2 inhibitor was 19.9% and 27.4%, respectively, in patients with comorbid atherosclerotic cardiovascular disease	Thank you for your comment and your helpful suggestion. The committee considered incorporating timeframes for starting subsequent therapies following initiation of metformin. They concluded that each person's titration time will be different and so may not reach the required dose in the timeframe suggested. Therefore, the time it takes to titrate to the optimum dose has not been stipulated to allow for individual variation. This is to be discussed on a case-by-case basis with the person as the guideline discusses in making each discussion a person centred process. A GP may consider the timeframe you suggest as an option as this has not been excluded by the guideline.

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				(ASCVD) and chronic HF, and uptake for patients at high risk of cardiovascular disease was 18.6%. The report emphasises the concerning low uptake of the SGLT2 inhibitor class, following the 2022 recommendations, and while the report called for the committee to consider 'whether recommendations, research recommendations, or other actions specifically on uptake of the guideline-recommended drugs should be made as part of or following the 2024 guideline update', AstraZeneca is disappointed to see the same recommendation as 2022 has been included, recommending to start with metformin and requiring confirmation of tolerability before an SGLT2 inhibitor can be prescribed.[2] This is particularly concerning given the low proportion of patients who discontinue metformin due to gastrointestinal side effects, estimated at around 5% of patients.[3] <u>Rationale</u> While AstraZeneca understands the rationale for introducing medicines in a stepwise manner, checking for tolerability and effectiveness of each medicine, AstraZeneca is concerned that the current requirement to 'check metformin tolerability' is vague, may be delaying the initiation of SGLT2 inhibitors and driving suboptimal care for patients	

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				with T2D. According to a CPRD analysis in October 2023 of patients with type 2 diabetes who initiated their first metformin prescription after the previous NG28 guideline was published in June 2022, it took an average of [This text was identified as confidential and has been removed] for an SGLT2 inhibitor to be initiated. The time to SGLT2 inhibitor initiation also varied regionally, ranging from an average of [This text was identified as confidential and has been removed] to [This text was identified as confidential and has been removed] across England.[4] This emphasises the current delay to initiation of guideline directed therapy and suggests that greater clarity is needed to further advise on when and how an SGLT2 inhibitor should be initiated following metformin tolerability confirmation. For example, after 10 to 15 days when dose titration is recommended in the metformin summary of product characteristics (SmPC).[5] Clear guidance would likely reduce the delay in initiation to an SGLT2 inhibitor when most patients (approximately 95% of patients) will tolerate metformin and so should receive an SGLT2 inhibitor as quickly as possible once T2D has been diagnosed.[3] It may also help to reduce variation in care across England.	

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				Pre-specified analyses from the DAPA-HF and DELIVER trials assessed the timing of onset of clinical benefit with dapagliflozin on clinically relevant outcomes for patients with HF with reduced ejection fraction, and HF with mildly reduced or preserved ejection fraction, respectively.[6, 7] Both analyses reported that dapagliflozin led to early and sustained reductions in clinical events, with the analysis of the DELIVER trial reporting statistically significant reductions within 2 weeks of treatment initiation. Similarly, an analysis of 3775 patients with T2D from the UK Clinical Practice Research Datalink (CPRD) reported the glycaemic benefits of dapagliflozin to be greater in people who received treatment early versus later.[8] The cost-effectiveness of SGLT2 inhibitors has been estimated at established clinical review points and incorporating the totality of proven health benefits.[1] Based on the subpopulations recommended SGLT2 inhibitors in the NG28 guideline published in 2022, SGLT2 inhibitors were reported to be cost-saving between 2- and 16-years post-initiation. Given the fact that dapagliflozin is now off patent in the UK and hence a significant price reduction in the SGLT2 inhibitor class is expected, it is likely that these treatments would be cost saving significantly earlier than this. Therefore,	

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				the quicker patients are initiated onto an SGLT2 inhibitor, the quicker they can benefit from treatment and the quicker the cost-benefits to the system can be realised. Summary To ensure the initiation of SGLT2 inhibitors is not delayed in patients eligible for treatment, and recommendation 1.8.34 does not cause implementation challenges, AstraZeneca would strongly recommend that recommendation 1.8.34 is updated to state: - When an adult with T2D starts initial therapy with metformin and one or more other medicines: - Introduce the medicines one at a time, starting with metformin If using an SGLT2 inhibitor, co-prescribe metformin and the SGLT2 inhibitor and advise patients to initiate metformin first, and after titration over 10-15 days to the target dose determined by the clinician, to then begin taking the SGLT2 inhibitor without delay if the metformin is tolerated	
AstraZeneca	Consultation questions		001	Concern In response to question 1 (would it be challenging to implement any of the draft recommendations?), AstraZeneca has concerns regarding the implementation of recommendation 1.8.34, which	Thank you for your comment. The committee considered incorporating timeframes for starting subsequent therapies following initiation of metformin. They concluded that each person's titration time will be different and so may not reach the required dose in that time. This is to be discussed on a

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				states that when an adult with T2D starts initial therapy with metformin and one or more other medicines: • 'If using a GLP-1 RA, start this as soon as the SGLT2 inhibitor tolerability is confirmed' Similar to the findings from the SGLT2 inhibitor uptake report,[2] AstraZeneca is concerned that the current requirement to confirm SGLT2 inhibitor tolerability is vague, may delay the initiation of GLP-1 RA and may lead to suboptimal care for patients with T2D. <u>Rationale</u> SGLT2 inhibitors and GLP-1 RA are generally well tolerated,[9] with distinct yet complementary mechanisms of action.[10, 11] A meta-analysis investigating the occurrence of various adverse events associated with SGLT2 inhibitors, including over 70,000 participants across key trials of the SGLT2 inhibitor class, reported the most common adverse event to be genital infections (3.6-fold increased risk compared to placebo) and diabetic ketoacidosis (DKA; 2.2-fold greater risk compared to placebo).[12] DKA is a side effect that can occur at any time during SGLT2 inhibitor treatment since risk factors include a very low carbohydrate or ketogenic diet, as stated by NICE in	case-by-case basis with the person as the guideline discusses in making each discussion a person-centred process.

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				recommendation 1.8.36, or conditions leading to restricted food intake or severe dehydration, surgery, alcohol abuse or a sudden reduction in insulin.[13] Therefore, this adverse event needs to be monitored throughout SGLT2 inhibitor treatment, and should not determine if a GLP-1 RA can be initiated, as required. In contrast, the highest risk of the most common adverse event reported across the SGLT2 inhibitor class, genital infections, has been observed within 15-28 days following the initiation of an SGLT2 inhibitor.[14] This strongly indicates a time frame when SGLT2 inhibitor tolerability can be confirmed, and when it is appropriate to initiate the GLP-1 RA in those eligible. In addition, the overall safety of combining SGLT2 inhibitors and GLP-1 RA has been demonstrated across randomised controlled trials, with adverse effects generally limited to those of the individual components.[15] The DURATION-8, phase 3, multicentre trial compared the efficacy and safety of co-initiation of exenatide and dapagliflozin with exenatide or dapagliflozin alone in 695 patients with T2D inadequately controlled by metformin.[16] Concomitant use of exenatide and dapagliflozin resulted in clinical improvements in glycaemic control, weight, and systolic blood pressure	

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				compared with use of either drug alone. The dual treatment regimen was well tolerated, with the expected safety profile for this combination.[16] Summary To ensure the initiation of GLP-1 RA is not delayed in patients eligible for treatment, and recommendation 1.8.34 does not cause implementation challenges, AstraZeneca would strongly recommend that recommendation 1.8.34 is updated to state: If using a GLP-1 RA, start this as soon as the SGLT2 inhibitor tolerability is confirmed. Tolerability of an SGLT2 inhibitor should be assessed within 28-days of initiation, once the target dose determined by the clinician has been reached. If tolerability has been confirmed, the GLP-1 RA should be initiated without delay	
AstraZeneca	Consultation questions		001	Concern In response to question 1 (would it be challenging to implement any of the draft recommendations?), AstraZeneca has concerns regarding the implementation of the guidance due to the format in which the final version is provided to healthcare providers and practicing clinicians. Currently, the	Thank you for your comment. NICE is currently implementing a new platform to enable the efficient creation, management and publication of guidance content. The platform will seek to ensure users find it easier to navigate to relevant guidance

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				final publication is typically disseminated via the NICE website as a downloadable PDF. This format may limit accessibility and ease of use for clinicians, potentially limiting the ability of NICE guidance to lead to improved clinical outcomes for patients and have a positive impact on the National Health Service (NHS). <u>Rationale</u> If a basic patient pathway is considered, such as: 1. Presentation 2. Initial assessment 3. Diagnosis 4. Treatment decision/ initiation 5. Monitoring/ follow-up It is reasonable to expect that technology will play an active role throughout each step of the patient's care. A key aspect is that the patient's care record is usually captured in Electronic Patient Record (EPR) software, which serves as the central hub for every interaction the patient has with their healthcare provider. EPR systems used across the UK are a core component of the digital backbone of primary care, as they not only capture and store patient data, but can also be leveraged to manage formularies and digitally disseminate guidance, such as through templates.	content, and that content is presented in a way that enables users to make decisions. Your feedback will be considered by NICE where relevant support activity is being planned.

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				Additionally, third-party software providers have the capability to integrate new services and solutions directly within native EPR platforms, offering clinicians extra support and timely guidance as part of routine clinical workflows. AstraZeneca sees these EPR systems as an opportunity to share updated clew commend clinical guidance more rapidly, broadly, and in an accessible digital format. <u>Summary</u> AstraZeneca recommends that NICE provide their guidance as downloadable digital templates that can be directly embedded into EPR systems such as EMIS and SystmOne. In addition, AstraZeneca encourages NICE to partner with third-party providers such as Ardens to further support integration and dissemination of guidance within platforms of this nature to provide better access and implementation.	
AstraZeneca	Consultation questions		003	In response to question 3: Should NICE update the existing technology appraisals for canagliflozin, dapagliflozin, empagliflozin, and ertugliflozin (TA288, TA315, TA336, TA390, TA418, TA572, TA583)? If so, please provide a rationale for this. Details of the update process are in NICE health technology evaluations: the manual, see 8.4 Surveillance decision options.	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.

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				<u>Concern</u> AstraZeneca have previously provided feedback relating to this topic as part of the consultation on PMG47 (Interim process and methods statement for bringing together NICE guidance) in 2024. The AstraZeneca position on the TA incorporation and integration approaches remains unchanged since this time, and we would like to reiterate our concern regarding the integration approach being suggested as part of the NG28 guideline update. <u>Rationale</u> AstraZeneca is supportive of continuing to work with NICE to ensure useful and usable guidance can be provided in a timely manner and believes the approach of incorporating NICE TA recommendations into NICE guidelines is a step in the right direction to achieve this goal. On the other hand, there are significant concerns and outstanding questions relating to the integration approach. Specifically considering the current proposal as part of the NG28 update, it remains unclear exactly how NICE propose to update the TAs for each of the SGLT2 inhibitors (e.g., the specific recommendation wording that NICE are proposing, how this would be	

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				reflected on the relevant NICE web page for each TA, and any accompanying explanation or change log which would be provided). Additionally, should the integration approach be implemented, it is not clear who would be responsible to fund the process, whether a full appraisal would be required, and whether such an update would impact the funding mandate associated with each TA. Without clarity on such critical and practical aspects of the proposed integration approach, it is challenging for consultees to provide meaningful feedback. Furthermore, given that the use of the integration approach as part of NG28 may act as a precedent for the use of similar approaches in other future guidelines, it is critical that any proposed process is carefully considered with a broad view of potential implications. To achieve this, the entire proposed process ought to be clearly outlined (including the practical aspects highlighted above), all relevant stakeholders should be consulted (including broader industry stakeholders outside those involved in NG28), and stakeholder concerns should be clearly considered and addressed before the approach is utilised. In particular, AstraZeneca would be highly concerned about any proposed approach for TA	

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				guideline integration which could undermine the funding mandate or narrow the eligible population outlined in existing TA guidance. This concern is due to the following considerations: - Ensuring that all cost-effective medicines should be made available to patients and that decision making on medicines should be made based on appropriate clinician choice to ensure patient outcomes are not at risk. It is important for clinicians to be able to consider specific characteristics of individual patients, which may not be formally captured in guideline recommendations - The current proposed approach to integration does not maintain the robust and rigorous TA process, nor does it align with the methods and processes across the different programmes - Any changes to the patient population or funding mandate would impact confidence in the NICE TA process and undermine the quality of NICE recommendations. Given the broader UK access environment, losing the stability previously associated with NICE TA recommendations may compound existing concerns about the attractiveness of the UK as a priority launch market.	

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				Summary AstraZeneca is supportive of continuing to work with NICE to ensure useful and usable guidance can be provided in a timely manner. However, since the consultation on PMG47, AstraZeneca is not aware that the key industry concerns and queries have been appropriately considered and addressed, nor subject to further consultation but would welcome further conversations. Therefore, we remain concerned regarding the proposed approach of integrating prior SGLT2 inhibitor TAs as part of the NG28 guideline update, and the potential precedent that this may set. Instead, an incorporation approach is considered most appropriate in the immediate term (i.e., ensuring that hyperlinks to the relevant TAs are provided throughout the NG28 guideline as appropriate), whilst further work is undertaken to explore possible approaches to guideline integration.	
AstraZeneca	General			Summary AstraZeneca would like to thank NICE for its commitment to advancing clinical care for patients with type 2 diabetes (T2D). AstraZeneca also continues to be fully committed to advancing care for patients across the spectrum of cardiovascular, renal and metabolic conditions. With this shared ambition and commitment to improve the lives of	Thank you for your comment. We will address each of your points in the appropriate sections.

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				patients with these long-term conditions in mind, AstraZeneca welcomes the opportunity to respond to the draft NICE T2D guidelines (NG28). AstraZeneca agrees with many of the recommendations set out by the committee in NG28, particularly the decisions to: • Include a stronger recommendation to 'offer' a sodium-glucose co-transporter-2 (SGLT2) inhibitor across most subgroups, reflecting the strength of the evidence for SGLT2 inhibitors for people with T2D. AstraZeneca would recommend that the cost-effectiveness analyses are updated following consultation to include the new Category M price for dapagliflozin, to ensure the incremental cost-effectiveness ratios (ICERs) are reflective of this price change, and demonstrate the further improved cost-effectiveness expected for the SGLT2 inhibitor class • Include T2D and chronic kidney disease (CKD) within the NG28 treatment algorithm, which represents a critical step to ensuring optimal care for this sizable patient	

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				population, in which SGLT2 inhibitors have demonstrated clinical effectiveness. AstraZeneca also agrees with the findings from the SGLT2 inhibitor uptake report and would like to emphasise the critical importance of ensuring SGLT2 inhibitor implementation challenges are overcome to realise the possible benefits to patients as well as the cost-savings to the healthcare system, particularly now the price of dapagliflozin has been reduced.[1, 2] However, AstraZeneca strongly feels that there are areas of the draft T2D guideline which represent significant missed opportunities to further improve the lives of patients and address areas of inequality of care. The main areas of concern include: The proposed recommendation to 'discuss the benefits and risks of each drug treatment option with adults with diabetes' provides inadequate detail of the patient centric factors which ought to inform this discussion, including route of administration given the practical implications for lifestyle integration, patient preferences, and psychological barriers	

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				- Given multiple therapies are available within a drug class with potentially similar efficacy and adverse event profiles, AstraZeneca is concerned that the removal of the recommendation to consider cost could increase spending on drug acquisition and administration - Currently, the draft recommendation to offer an SGLT2 inhibitor for patients with heart failure (HF) does not reflect the differences in the robustness of the evidence, licenced populations or NICE recommendations of the available SGLT2 inhibitors. An inconsistent approach has been applied compared with that followed for the CKD subgroup, where dapagliflozin and empagliflozin are specifically recommended because they are the only SGLT2 inhibitors licensed for use - The draft recommendation for patients with T2D who 'have a level of frailty that places them at risk of adverse events from SGLT2 inhibitors' is vague, in misalignment to the cited guidance to inform a diagnosis of frailty and could lead to under-prescribing of SGLT2 inhibitors in patients with frailty	

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				who are eligible and would benefit from treatment - While AstraZeneca understands the rationale for introducing medicines in a stepwise manner, the draft recommendation to 'introduce medicines one at a time, starting with metformin and checking tolerability' and 'if using a glucagon-like peptide-1 receptor agonist (GLP-1 RA), start this as soon as the SGLT2 inhibitor tolerability is confirmed' may delay the initiation of SGLT2 inhibitors and GLP-1 RA and drive suboptimal care for patients with T2D. AstraZeneca is concerned that the language to confirm tolerability is not sufficiently specific and may lead to variation in care and a slow implementation of the NICE recommendations - The approach taken in the cost-effectiveness model to compare treatment choices to metformin monotherapy without a clear subsequent treatment pathway does not accurately reflect treatment escalation in clinical practice or in the draft guideline, resulting in ICERs that may not represent	

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				the corresponding treatment recommendations When assessing the cost-effectiveness of the subgroup of patients that suffer from T2D and obesity, NICE has previously concluded that incretin mimetics offer significant benefits in terms of weight loss, however these benefits are not reflected in the current analysis. This includes: use of conservative, non-specific data for GLP-1 RA weight loss, despite high quality evidence available; a linear relationship between body mass index (BMI) and quality of life, which does not align with previous NICE technology appraisal (TA) precedents; exclusion of broader benefits, including obstructive sleep apnoea, knee replacement and non-alcoholic fatty liver disease (NAFLD). Furthermore, since the consultation on PMG47 in 2024, AstraZeneca is not aware that the key industry concerns and queries have been appropriately considered and addressed, nor subject to further consultation. Therefore, AstraZeneca still has significant concerns and outstanding questions relating to the proposed	

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				approach of integrating prior SGLT2 inhibitor TAs as part of the NG28 guideline update, and the potential precedent that this may set. Without clarity on such critical and practical aspects of the proposed integration approach, it is challenging for consultees to provide meaningful feedback on this proposal. The evidence for these concerns and suggested changes to the recommendations are outlined in detail in the sections below, as well as some additional comments. AstraZeneca respectfully requests the Committee to consider these important additions with a view to improving the speed and quality of care for patients with T2D in the United Kingdom (UK).	
AstraZeneca	Guideline	General		<u>Concern</u> While AstraZeneca is supportive of the new guidelines considering the overlap between T2D and broader comorbidities, including HF and CKD, NG28 does not link to other relevant NICE documents which provide key guidance for diagnosis and management of the comorbidity. Furthermore, the cost-effectiveness analysis does not assess patients with multiple interrelated comorbidities. <u>Rationale</u>	Thank you for your comment. We acknowledge the comorbidities associated with type 2 diabetes and have included links to chronic kidney disease, hypertension, overweight and obesity management, clinically assessing and managing multimorbidity, throughout the guideline. Additionally, given the risk of comorbidities, all people with T2DM were classified as having high risk of cardiovascular disease if they did not have cardiovascular disease or a relevant disorder. We acknowledge the concerns around the uptake of dual or triple therapies and have highlighted the importance of introducing medicines one at a time and reviewing medicines

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				It is highly likely that people with T2D will have one or more interrelated comorbidities. Diabetes has been reported to occur in 25%-40% of patients with HF, while CKD was reported in 42%-53% of patients with HF, and 40% of patients with diabetes.[17, 18] Patients with two or more of these comorbidities experience a higher risk of hospitalisation, kidney failure and mortality.[19-21] The NG28 guideline alludes to the comorbid nature of T2D, but no clear guidance is offered on suggested management, stating that 'if a person has more than one comorbidity (for example, cardiovascular disease and obesity), make a shared decision with them about which comorbidity to prioritise when choosing medicines'. To overcome this challenge, AstraZeneca proposes that NICE refers to appropriate guidance that provides further information on the diagnosis and management of the comorbidity. For example, to appropriately consider the diagnosis and management of CKD, the NG28 guideline could refer to NG203 in multiple sections:[22] • NG28 recommendation 1.8.7 to assess the persons' current cardiovascular and renal status, and risk of developing cardiovascular disease in the future could refer to recommendation 1.1.21 in NG203	with a healthcare professional. Additionally, a research recommendation has been made to investigate barriers to the uptake of SGLT-2 inhibitors. Regarding the cost-effectiveness analysis not accounting for patients with multiple co-morbidities, the committee noted that, in practice, clinicians would prioritise management based on the most pressing clinical need. In the example of a patient who develops heart failure, the clinician would turn to the recommendations specific to the heart-failure population to guide treatment decisions.

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				which states to offer estimated glomerular filtration rate (eGFR) creatinine and albumin-to-creatinine ratio (ACR) testing to adults with diabetes NG28 recommendation 1.8.24 for people with T2D and CKD could refer to recommendation 1.6.6 in NG203 which states for adults with CKD and diabetes to offer an angiotensin receptor blocker (ARB) or an angiotensin converting enzyme (ACE) inhibitor (titrated to the highest licensed dose that the person can tolerate) if ACR is 3 mg/mmol or more. Furthermore, the approach to modelling has assumed that comorbidities are treated independently of each other, with no dynamic treatment pathway dependent on the comorbidities that patients may develop. For example, if a patient develops HF during the model, they would likely initiate an SGLT2 inhibitor, which would have an impact on treatment outcomes related to other comorbidities, such as CKD. However, these benefits are not captured underestimating the benefit of treatment. <u>Summary</u>	

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				AstraZeneca recognises that this is a T2D guideline and is pleased to see a broader consideration of multimorbid patient populations. However, given the points above, AstraZeneca recommends that the NG28 guideline includes references throughout to relevant NICE guidelines which may support in the diagnosis and management of the comorbidities associated with T2D. This should support the management of these complex and interconnected diseases and implementation of the recommendations to clinical practice. Additionally, AstraZeneca would recommend for NICE to consider a broader evidence base for patients with T2D and related to comorbidities and explore how the cost-effectiveness model could analyse these patients. These analyses should serve as a basis to generate more specific recommendations for patients with multiple comorbidities.	
AstraZeneca	Health economic analysis	General		Concern In TA1026 and TA875, NICE concluded that incretin mimetic therapies may offer significant weight loss benefits and are likely a cost-effective use of NHS resources for adults with overweight and obesity who meet the NICE recommendation criteria. Despite this, the benefits of achieving weight loss following treatment with GLP-1 RAs in the NG28 model have not reflected the precedents set in	Thank you for your comment. The weight rebound estimates used in the base case were based on committee assumptions in the absence of data from randomised-controlled trials. A sensitivity analysis explored the impact of sustained weight loss with SGLT-2 inhibitors and GLP-1 receptor agonists over the full time horizon (section 2.4.7). This gave ICERs that were lower than those reported in the base case (section 3.2.7). Cardiorenal outcomes predicted by the UKPDS model were calibrated to match outcomes reported in the clinical review

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				TA1026 and TA875 and hence have not been fully captured across the economic analyses. Rationale The impact of weight loss is currently incorporated into the economic model as a change in median weight based on outputs from the network meta-analysis (NMA) in year 1 (applied to all modelled treatment arms) and data from CPRD in years 2–4 (applied only for SGLT2 inhibitors and GLP-1 RA). From year 4, weight loss is assumed to revert to baseline over 2 years (SGLT2 inhibitors) or 1 year (GLP-1 RA). Weight is assumed to naturally increase at a rate of 0.1 kg/year thereafter for metformin monotherapy, and the weight in any given year for someone on treatment with a GLP-1 RA or an SGLT2 inhibitor was 0.1kg less than for metformin alone. Importantly, the rebound assumption is not evidence-based and favours weight loss for SGLT-2 inhibitors. This weight rebound assumption forces GLP-1 RA weight loss benefits to be lost within 1 year, disproportionately eroding GLP-1 RA weight loss benefits against real-world data, which shows durable weight loss effects for GLP-1 RAs while patients remain on therapy. This rebound assumption has no foundation in clinical evidence and does not align with previous NICE HTAs in obesity.	NMA. As a result, BMI directly influences the risk of ulcerations and the additional quality of life when BMI is 25 kg/m² or more. Other weight-related outcomes, specifically obstructive sleep apnoea, knee replacement, NAFLD and cancers were not listed in the review protocol and therefore not incorporated into the model. Given that many of the weight-related estimates were based on assumptions, we conducted multiple sensitivity analyses. These showed that the model results were robust to these variations.

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				BMI affects the risk of chronic HF, peptic and pressure ulcers and renal failure. However, the primary impact is a utility decrement of -0.0061 per 1 unit increase in BMI over 25 kg/m². As a result of this methodology, changes in weight will only have a small impact on the risk of chronic HF, ulcer and renal failure, with additional outcomes including quality adjusted life year gains being driven by the decrement for BMI above 25 kg/m². Application of a uniform utility decrement is highly impactful and does not reflect clinical evidence, undervaluing the weight loss benefits in the proposed economic model. Evidence described during TA875 and TA1026 demonstrates that HRQoL declines faster at higher BMI levels, and that a logarithmic function, or alternative non-linear approach, better captures the disproportionate HRQoL gains from reductions at higher BMI levels. As the GLP-1 RA therapies included in the economic model may deliver favourable weight loss outcomes, particularly in patients with higher BMI, the linear approach used in the economic analysis potentially underestimates the QALY benefits of GLP-1 RAs. By contrast, economic analysis for TA1026 included several comorbidities and clinical effects that have a significant impact on healthcare costs and quality	

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				of life, including obstructive sleep apnoea, knee replacement and NAFLD. Further, the committee noted that other clinical events such as cancer may be influenced by BMI, and these had not been captured in the model. Additionally, during TA1026, the committee preferred to assume that weight would be regained in 2 years after stopping treatment. A comparison of approaches between the draft guideline and TA1026 is provided below: • The economic model uses conservative and non-specific data for GLP-1 RA weight loss, as opposed to observed values for tirzepatide and semaglutide reflecting increasing efficacy versus early GLP-1 RAs, as seen in previous NICE TAs • The economic model uses a linear relationship between BMI and quality of life, which does not align with the non-linear approach used in TA1026, reflecting greater quality of life gains at higher BMI reductions • The economic model assumes that weight rebound occurs over 1 year for GLP-1 RAs, versus 2 years for SGLT2 inhibitors. During TA1026, this assumption was 2 years for incretin mimetics including GLP-1 RAs,	

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				potentially biasing against GLP-1 RAs in the economic model without any evidence to support a changing assumption The economic model excludes broader metabolic benefits modelled during TA1026, including obstructive sleep apnoea, knee replacement and NAFLD. The collective impact of these assumptions on the cost-effectiveness of GLP-1 RA is demonstrated in the scenario analysis in which people were assumed not to regain weight to baseline levels. During this scenario, there was an incremental QALY gain of only +0.01 when compared to base case results. Given the proven health benefits of long-term weight loss, this suggests that the modelled weight loss benefit lacks clinical face validity. Summary AstraZeneca recommends alignment with the preferences and approaches in TA1026 and consideration of the broader benefits, including obstructive sleep apnoea, knee replacement and NAFLD, that may be realised through achieving weight loss, including how other chronic conditions may be affected and overlap within the economic model.	

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AstraZeneca	Health economic analysis	General		<u>Concern</u> Since the search strategies were conducted in March 2024, key clinical evidence including the SOUL trial was not yet published and so not identified in the systematic literature review. As a result of this, significant clinical evidence that may have impacted the cost-effectiveness analysis and subsequent draft guideline recommendations was not included. <u>Rationale</u> The SOUL trial studied the cardiovascular efficacy of oral semaglutide in people with T2D and ASCVD, CKD, or both.[47] This study demonstrated oral semaglutide to be associated with a significantly lower risk of major adverse cardiovascular events compared with placebo. As a result of the omission of this study from the literature review and NMA, the hazard ratio for major outcomes was set to a null value of 1 in the economic model, implying that oral semaglutide had no effect on outcomes, likely impacting decision-making. However, if data from SOUL was included this may have favourably impacted the cost-effectiveness ICER, potentially resulting in oral semaglutide being considered a cost-effective treatment option and potentially impacting the draft recommendations made, particularly for the ASCVD subgroup. A positive	Thank you for your comment. The SOUL study has now been incorporated into the guideline review. Its inclusion did not alter the overall findings or the resulting cost-effectiveness estimates.

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				recommendation would improve patient choice and allow access to an oral GLP-1 RA treatment option for patients who may benefit from this mode of administration. While AstraZeneca acknowledges that the study was published in March 2025, after the search strategies were conducted, it is essential that NICE is able to establish a process that enables a comprehensive and rolling assessment of emerging data to ensure that the totality of available evidence can inform recommendations as effectively and accurately as possible. NICE has recognised that there are likely to be new medicines coming through which may offer greater clinical and cost-effectiveness in the near future and that the guideline should be reviewed once new medication becomes available. Summary AstraZeneca recommends implementing a robust and time-efficient process, triggered by the availability of new medicines, to ensure that new clinical evidence is promptly incorporated into the economic model and reflected in guideline recommendations. Additionally, AstraZeneca recommends that the guideline should be fully up to date before publication and account for the most	

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				recent evidence available to ensure recommendations are accurate and relevant to current clinical practice.	
AstraZeneca	Health economic analysis	General	General	<u>Concern</u> The committee have not considered how the recent price reduction for dapagliflozin would impact the cost-effective analysis, ICERs and consequent decision-making. <u>Rationale</u> While the Category M price for dapagliflozin has been updated, the ICERs reported in the committee's economic analysis report do not reflect this change.[1] A lower price of dapagliflozin would likely result in more cost-effective ICERs, thereby strengthening the position of SGLT2 inhibitors as a first-line recommendation for many of the patient cohorts. The improved cost-effectiveness is expected to impact the triple therapy regimens combining SGLT2 inhibitors and GLP-RAs.	Thank you for your comment. The updated analyses reflect drug prices as of November 2025, which factors in the category M price for dapagliflozin. This resulted in lower ICERs for SGLT-2 inhibitors as part of dual therapy with metformin and triple therapy with GLP-1 receptor agonists and metformin. However, triple therapy was still not cost-effective compared with dual therapy.
AstraZeneca	Visual summary	002		<u>Concern</u> In the current NG28 visual summary document, page 4 and 5 includes a tabulated summary of first-line medicines, and medicines for further treatment, respectively. Both tables list medical options for each recommended treatment class, for example SGLT2 inhibitors and GLP-1 RAs, and summarise	Thank you for your comment. . Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact sections of the guideline. If a person requires additional information regarding the different therapies

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				information likely to impact prescribing choice, for example, impact on weight, hypoglycaemia risk, renal and hepatic impairment. In the draft visual summary, this table has been omitted, removing this useful resource. Given the draft recommendations now refer to the GLP-1 RA class, and the tirzepatide (a dual GLP-1/ glucose-dependent insulintropic polypeptide [GIP] RA) TA, AstraZeneca is concerned that enough clarity has not been provided regarding the different mechanisms of action of these therapies and impact on clinical effect. This will become increasingly important as new mechanisms of action launch for the treatment of T2D. <u>Rationale</u> The draft guideline makes recommendations for the GLP-1 RA class, subcutaneous semaglutide, and also refers to the tirzepatide TA [TA924]. Tirzepatide is a dual GLP-1/GIP RA, and, therefore, is a different mechanism of action to the GLP-1 RA class. This new mechanism of action has been shown to have a different clinical effect to the GLP-1 RA class and, consequently, has a differential impact on factors which are likely to impact prescribing. Furthermore, there are multiple	available, a link has been included in column 6 which takes a person to NICE's information on prescribing medicines. From this page, the British National Formulary (BNF) can be accessed which will link a person with the most up-to-date information for all the relevant medicines.

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				therapies with novel mechanisms of action in development for the treatment of T2D, including: • CagriSema, a dual amylin and calcitonin receptor agonist(DACRA)/GLP-1 RA being investigated in the Phase 3 REIMAGINE programme with expected completion during 2025/2026 • Retatrutide, a GLP-1/ glucagon (GCG)/ GIP RA being investigated in the TRANSCEND programme with expected completion during 2026/2027 As new therapies launch with novel mechanisms of action and potentially greater clinical effectiveness, and the landscape becomes more complex, it is critical that NG28 provides the necessary information to inform treatment decisions. <u>Summary</u> AstraZeneca requests that the tabulated summary of first-line medicines, and medicines for further treatment, currently included in the published NG28 visual summaries is added into the draft visual summary document. The table should summarise the current GLP-1 RA therapies available, the different mechanisms of action between the GLP-1 RA class, and the new dual GLP-1/GIP RA, and further information likely to impact prescribing	

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				choice, for example, route of administration, impact on weight, hypoglycaemia risk, renal and hepatic impairment. This would also provide a clear location where the differences between the currently available therapies, and potential new therapies would be captured.	
AstraZeneca	Guideline	015	001	Concern AstraZeneca agrees with the draft guideline now placing more focus on supporting people to make an informed decision about their treatment. However, draft recommendation 1.8.1 to 'discuss the benefits and risks of each drug treatment option with adults with diabetes' provides inadequate detail about the types of patient-centred considerations which ought to inform this discussion. This may result in inconsistent guidance being provided by clinicians to patients, and cause disparities in adherence and outcomes. This is relevant to the response to question 1 (Would it be challenging to implement any of the draft recommendations?), as implementing the guideline in its current form could lead to heterogeneity and inconsistency. Rationale The draft NG28 guideline now places more focus on supporting people to make an informed decision	Thank you for your comment. We agree that these factors should be involved in this discussion and have added that factors that might prevent a person from following a specific treatment option should be taken into account. Further information about shared decision making is provided and are discussed in the NICE guideline on shared decision making which is cross referenced in the recommendation.

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				about their treatment. AstraZeneca believes that this patient-centred approach will help patients to determine the optimal therapy for them, improving adherence and outcomes. However, with multiple therapeutic options available within a treatment class (for example, five GLP-1 RA), and with injectable agents now being recommended for the first time in a first line position for a potentially large cohort of people, AstraZeneca believes it is important to provide comprehensive and consistent guidance when discussing treatment options to ensure patients are equipped to make an informed decision. Additionally, it is important that patients are aware of the importance of treatment adherence to be able to benefit from treatment in both the short and long-term. To achieve the potential benefits of individualised care, such conversations should include considerations beyond the effectiveness of each treatment option, and should ensure adequate discussion relating to patient centric factors including route of administration, given the practical implications for lifestyle integration, patient preferences, and psychological barriers: • Different routes of administration may lead to varying adverse events in patients, so	

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				when discussing the route of administration, for example oral versus injectable formulations of semaglutide, the risk of adverse events should be communicated.[23] • People with T2D may have a preference for an oral therapy; anxiety and fear of injection-associated pain are estimated to affect approximately 30-50% of patients.[24] • Oral semaglutide is required to be taken on an empty stomach after a recommended fasting period of at least 8 hours, and patients must wait at least 30 minutes before eating, drinking or taking other oral medicinal products.[25] • Initiating an injectable agent requires education about injection technique, dosing schedules, and titration protocols.[26-28] This may be challenging for some individuals, especially those who may be managing multiple medications already or those suffering from learning difficulties.[29] Summary AstraZeneca believes that it is important to ensure the points highlighted above are incorporated when involving people in medicine discussions, and	

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				therefore requests that recommendation 1.8.1 is updated to include: - Discuss the importance of treatment adherence and the benefits and risks of each drug treatment option with adults with T2D and support them to make an informed decision about their treatment. Ensure the person's individual preferences and needs are discussed, and a patient is informed of the different adverse event profiles, and practical considerations of different routes of administration - Take into account the effectiveness of each medicine in terms of: - Metabolic response and - Cardiovascular and renal protection	
AstraZeneca	Guideline	015	001	<u>Concern</u> AstraZeneca agrees with the draft guideline now placing more focus on supporting people to make an informed decision about their treatment. However, with multiple therapies available within each drug class with potentially similar efficacy and adverse event profiles, AstraZeneca is concerned that the removal of a consideration of cost is inappropriate and could increase spending on drug acquisition and administration.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee

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				<u>Rationale</u> The previous version of NG28 included cost as a consideration when choosing drug treatment, stating that if two drugs in the same class are appropriate, choose the option with the lowest acquisition cost. Class level recommendations imply that all drugs within the class are appropriate in all patient populations, which may not reflect the differences in the available clinical and cost-effectiveness evidence. AstraZeneca believes that evidence-based guidelines should consider cost-effectiveness rather than acquisition cost alone and so urges NICE to recommend the consideration of efficacy as well as broader administration costs. Therefore, it is requested that recommendation 1.8.1 is updated to include 'if two drugs in the same class are equally suitable for a particular patient, after discussing the advantages and disadvantages of all the options, the least expensive should be used. Administration costs, dosages and price per dose should all be taken into account'. This wording would align to recommendations previously made by NICE during the cost-comparison evaluation of dapagliflozin in TA1075 for the treatment of chronic kidney disease.[30]	considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).

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				Additionally, NICE has recognised that dapagliflozin is now off patent in the UK initiating a significant cost decrease, with the launch of generic alternatives, which will impact the cost-effectiveness of the SGLT2 inhibitor class. Given that NICE has made a class level recommendation for the SGLT2 inhibitors, inclusion of this suggested wording would enable prescribing to align with recent changes in the treatment landscape which could offer greater savings to the NHS. <u>Summary</u> AstraZeneca believes that it is important to ensure the points highlighted above are emphasised when deciding which therapy within a class to prescribe, and therefore requests recommendation 1.8.1 is updated to include: If two drugs in the same class are equally suitable for a particular patient, after discussing the advantages and disadvantages of all the options, the least expensive should be used. Administration costs, dosages and price per dose should all be taken into account	
AstraZeneca	Guideline	018	014	<u>Concern</u> Currently, the draft recommendation 1.8.12 for people with HF does not reflect the differences in the robustness of the evidence, licenced populations or NICE recommendations of the	Thank you for your comment. The current UK marketing authorisations for SGLT-2 inhibitors are for the treatment of adults with type 2 diabetes mellitus (T2DM). Heart failure is not a separately licensed indication in section 4.1 of the SmPC.

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				available SGLT2 inhibitors. An inconsistent approach has been applied compared with that followed for the CKD subgroup, where dapagliflozin and empagliflozin are specifically recommended because they are the only SGLT2 inhibitors licensed for use. <u>Rationale</u> Differences in the robustness and breadth of the available evidence for each SGLT2 inhibitor are reflected in the licenced population for each drug, which are summarised in Table 1. Importantly, only two of the available SGLT2 inhibitors (dapagliflozin and empagliflozin) have sufficient evidence of efficacy and safety in patients with CKD and HF to support a marketing authorisation in these populations. Table 1. Comparison of current SGLT2 inhibitor licenses in the UK <table><thead><tr><th></th><th>Indicated for T2D</th><th>Indi</th></tr></thead><tbody><tr><td>Canagliflozin</td><td>Yes</td><td></td></tr><tr><td>Dapagliflozin</td><td>Yes</td><td></td></tr><tr><td>Empagliflozin</td><td>Yes</td><td></td></tr><tr><td>Ertugliflozin</td><td>Yes</td><td></td></tr></tbody></table>		Indicated for T2D	Indi	Canagliflozin	Yes		Dapagliflozin	Yes		Empagliflozin	Yes		Ertugliflozin	Yes		However, section 5.1 of the SmPC includes data on heart failure outcomes, reflecting the regulatory assessment that these results are consistent with, and supportive of, the overall benefit–risk profile of SGLT2 inhibitors in T2DM. Therefore, it is appropriate to consider the benefits on heart failure outcomes within the scope of the approved indication when evaluating SGLT2 inhibitors for patients with T2DM. Given this, the committee agreed that a class based recommendation was appropriate in this circumstance.
	Indicated for T2D	Indi																		
Canagliflozin	Yes																			
Dapagliflozin	Yes																			
Empagliflozin	Yes																			
Ertugliflozin	Yes																			

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				Footnotes: *Canagliflozin can be used for the treatment of diabetic kidney disease as add on to standard of care (e.g. ACE-inhibitors or ARBs). Abbreviations: CKD: chronic kidney disease; HF: heart failure; T2D: type 2 diabetes. Multiple international, multicentre, double-blind, randomised controlled cardiovascular outcome studies underpin the license extension of dapagliflozin and empagliflozin to include HF. Both the DAPA-HF and EMPEROR-REDUCED trials, including 4744 patients and 3730 patients, respectively, with HF and a reduced ejection fraction demonstrated the effectiveness of dapagliflozin and empagliflozin to reduce the risk of worsening HF or death from cardiovascular causes, regardless of the presence or absence of T2D.[31, 32] Similarly, the DELIVER and EMPEROR-Preserved trials including 6263 and 5988 patients, respectively, with HF and a left ventricular ejection fraction of more than 40% demonstrated the effectiveness of dapagliflozin and empagliflozin to reduce the risk of worsening HF or cardiovascular death in patients with or without T2D.[33, 34] While canagliflozin was investigated in patients with T2D with and without a history of cardiovascular	

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				disease in CANVAS, the primary endpoint was a composite of cardiovascular death, nonfatal myocardial infarction, or nonfatal stroke, and the risk of HF hospitalisation was only reported as a secondary endpoint.[35] Similarly, the primary endpoint of VERTIS CV, a study assessing the efficacy of ertugliflozin in patients with T2D and cardiovascular disease, was the time to first major adverse cardiovascular event and the risk of hospitalisation for HF was reported as secondary outcome.[36] Therefore, compared with the broader SGLT2 inhibitor class, it is indisputable that the strength of the evidence for dapagliflozin and empagliflozin is stronger for patients with HF and regardless of the presence or absence of T2D. A similar strength of evidence is not available for other SGLT2 inhibitors and so evidence should not be considered equivalent across the SGLT2 inhibitor class. These differences in the marketing authorisations and evidence bases across the SGLT2 inhibitors are also reflected in the fact that only dapagliflozin and empagliflozin have positive NICE recommendations in HF (dapagliflozin: TA902 and TA679; empagliflozin: TA929 and TA733). Canagliflozin and ertugliflozin are not NICE recommended for patients with HF and	

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				consequently do not have a funding mandate for this patient population. Further, if the draft guideline does not specifically mention dapagliflozin and empagliflozin in the guideline recommendation, it will create misalignment with NG106 for the management of chronic HF, published on the 3rd of September 2025, and NG203 for the management of CKD, both of which specifically reference the relevant NICE TAs when recommending SGLT2 inhibitors.[22, 37] It also creates internal inconsistency within the NG28 guideline itself, where dapagliflozin and empagliflozin are specifically recommended in the subgroup of patients with comorbid CKD (with a rationale citing their marketing authorisations in this setting), but not in the subgroup of patients with comorbid HF, despite the fact that a similar rationale ought to apply in both subgroups. <u>Summary</u> AstraZeneca believes that it is important to reflect the differences highlighted above in the recommendations, and therefore requests that recommendations 1.8.12 is updated in line with this: For adults with T2D and HF offer metformin, and either dapagliflozin or empagliflozin	

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AstraZeneca	Guideline	022	010	<u>Concern</u> Recommendation 1.8.30 states that for adults with T2D who have a level of frailty that places them at risk of adverse events from SGLT2 inhibitors: - Consider metformin alone - If metformin is contraindicated or not tolerated, consider a DPP-4 inhibitor. Recommendation 1.8.32 states to 'Consider reviewing the person's overall diabetes treatment plan to ensure that they are taking the smallest effective number of medications, at the lowest effective dosage'. AstraZeneca is concerned that the statement on frailty is too vague and will lead to under-prescribing of SGLT2 inhibitors in patients with T2D who are eligible and would benefit from treatment. Additionally, within the visual summary figure, recommendation 1.8.32 is visually placed in the box with recommendation 1.8.30 ('if level of frailty places the person at risk of adverse events from SGLT2 inhibitors'), which may be confusing, as this would imply that this review should be undertaken in those people at risk of adverse events from SGLT2 inhibitors. However, as stated in the draft guidance, this review should be considered for all patients with diagnosed frailty.	Thank you for your comment. The committee have added specific examples of the adverse events that they are concerned about. They believe that this statement is more specific than providing frailty scale grades as these are often automatically coded and can lead to incorrect assignment of people into groupings, leading to people not receiving treatments that are appropriate for them and creating health inequalities. The committee agreed during deliberation that clinically significant frailty was not a specific term that has been defined and adopted universally by the medical community and so could be used in a recommendation in a meaningful way. Therefore, they believe that this is the more pragmatic method of deciding whether treatment is appropriate for someone or not. By making this statement, this means that people who have frailty where they agree with their healthcare professional that the risk is manageable, that they can consider this treatment strategy.

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				<u>Rationale</u> There is strong clinical evidence which demonstrates that patients with frailty can experience significant benefit from dapagliflozin treatment. Post hoc analyses of the DAPA-HF, DELIVER and DAPA-CKD trials assessed the efficacy and safety of dapagliflozin according to frailty status as defined by the Cumulative Deficit model, a model recognised by the British Geriatrics Society.[38-42] All three analyses demonstrated that while greater frailty was associated with more impairment in health status and worse clinical outcomes, including hospitalisations and death, the beneficial effects of dapagliflozin compared with placebo on clinical outcomes were consistent regardless of frailty class. Adverse events, although more frequent in patients with a greater degree of frailty, were not more common in those randomised to dapagliflozin compared with placebo.[40-42] Therefore, some patients with frailty may benefit from the proven benefits of SGLT2 inhibitors and so should be considered for treatment. The use of SGLT2 inhibitors in certain people with frailty is supported by a position statement published on behalf of the Association of British Clinical Diabetologists (ABCD).[43] The position	

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				statement recommends that multiple classes of therapies can be used in frail older adults with diabetes, including SGLT2 inhibitors, but with caution. The statement summarises the advantages and disadvantages of SGLT2 inhibitor treatment, and advises the following: 'In frail adults, watch for increased urinary frequency, incontinence, lower blood pressure, genital infections, dehydration; do not initiate if eGFR is <60 mL/min; dose reduction required in the presence of renal impairment; withhold SGLT2 inhibitors at times of acute illness or major surgery'.[43] Consequently, AstraZeneca would request that recommendation 1.8.30 states to consider metformin alone only if a patient with diagnosed frailty has a specific complication which may place them at an increased risk of an adverse event from SGLT2 inhibitor treatment, as per the SmPC. This would ensure that the recommendation does not discourage prescribing in people with frailty who could benefit from an SGLT2 inhibitor. Furthermore, the statement 'adults with T2D who have a level of frailty that places them at risk of adverse events from SGLT2 inhibitors' is extremely vague and does not align to published frailty definitions. Widespread uncertainty has been reported among primary care clinicians in England on how to define and classify frailty. Clinicians lack	

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				formal training on frailty and often do not conduct a formal frailty assessment.[44] Although the NG28 guideline references NG56 on clinically assessing and managing multimorbidity, which recommends four potential methods to conduct a frailty assessment in primary and community care settings, none of the assessments provide clarity on what level of frailty would place a person with T2D at an increased risk of adverse events from SGLT2 inhibitors.[45] If a frailty subgroup is included in the NG28 treatment algorithm, AstraZeneca believes NICE needs to go further in defining 'clinically significant frailty' in the section terms used in this guideline, and removing the statement 'level of frailty that places them at risk of adverse events from SGLT2 inhibitors'. AstraZeneca is also concerned that given the challenges in assessing and classifying frailty, there is a significant risk that the current wording could result in bias, whereby older patient groups may be inappropriately excluded from being offered an SGLT2 inhibitor. This could compound the findings from the Equality and Health Inequalities Assessment report, which identified SGLT2 inhibitors to be under prescribed, and highlighted age to be strongly negatively associated with a lower percentage of patients with an SGLT2	

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				inhibitor prescription. This further supports why a definition of 'clinically significant frailty' should be included in the guideline. Additionally, the visual summary is misleading as it suggests that recommendation 1.8.32, to conduct a medication review, only applies for people with a level of frailty that places them at risk of adverse events from SGLT2 inhibitors. According to Diabetes UK, polypharmacy is often defined as using five or more medications, and is common in people living with diabetes, especially as they get older.[46] Therefore, the medication review is an important recommendation and so it should be clearer in the visual summary that the review is recommended for all people with diagnosed clinically significant frailty. Summary AstraZeneca would recommend that the following recommendations are updated: 1.8.30. For adults with T2D who have been formally diagnosed with clinically significant frailty, and who have a specific complication which may place them at an increased risk of adverse events from an SGLT2 inhibitor, consider metformin alone.	

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				The visual summary figure needs to be updated to make it clear that recommendation 1.8.32 for a medication review is for all patients with formally diagnosed clinically significant frailty, and not just for when 'a level of frailty places the person at risk of adverse events from SGLT2 inhibitors'. A definition of 'clinically significant frailty' should be included in the terms used in this guideline section.	
AstraZeneca	Health economic analysis	022	002	<u>Concern</u> While previous NG28 guidelines included a clear intensification approach, the committee considered it too glucose-centric in nature and not reflective of current clinical practice. The approach taken in the proposed model compares treatment choices to metformin monotherapy without a clear subsequent treatment pathway. As a result, the modelling approach is not reflective of treatment escalation in clinical practice, hence the ICERs estimated may not represent the corresponding treatment recommendations made in the guideline, and there is a risk that the modelling does not effectively inform or guide the recommendations. <u>Rationale</u> bagust based on a clear "intensification approach", which meant that the next line of treatment would be applied once patients moved beyond a specific	Thank you for your comment. During development, the committee considered whether or not to model a treatment intensification pathway. They desired to move away from a glucose-centric approach and instead adopt a more holistic framework for diabetes management. It is worth noting that when a person progresses through to a stage where treatment intensification to manage HbA1c is required, they may experience additional gains in QALYs, but they may also incur higher costs. As a result, the cost-effectiveness of the initial treatment strategy becomes dependent on the cost-effectiveness of the subsequent intensification therapy. This relationship can differ depending on which first-line option was used, because different initial treatments may lead to different intensification pathways and associated outcomes. Given this dependency, the cost-effectiveness of first-line treatments is easier to interpret

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				haemoglobin A1C (HbA1c) threshold (7.5%). The proposed modelling approach for 2025 does not include any intensification following initial treatment. The reason given for this was that: "Given the move away from a glucose-centric treatment intensification approach, and that mapping out a treatment intensification algorithm that is dependent on multiple factors would be complicated in the first instance and incorporate added uncertainty at each level of intensification, it was decided to model subsequent treatment choices to metformin monotherapy in the pre-defined cohorts". Nonetheless, a recent publication using the Cardiff model that has incorporated a dynamic intensification approach based on factors beyond a patient's HbA1c and glycaemic targets, including cardiovascular risk, comorbidities and bodyweight suggests the choice of intensification approach is a key feature to appraising cost-effectiveness in diabetes.[48] The dynamic approach enabled early introduction of SGLT2 inhibitors and GLP-1 RAs primarily due to elevated cardiovascular risk, and compared to the conventional glucose centric approach, patients experience fewer clinical events and gain additional health benefits.[48] Despite the model used in the draft guideline not accounting for a clear intensification approach,	in scenarios where no intensification occurs, as the results are not influenced by downstream treatment choices. The McEwan 2025 analysis, which applied the Cardiff model and dynamic intensification, shows that many of the eligibility criteria for SGLT-2 inhibitors (for example obesity and heart disease) are already present in the populations we modelled. This suggests that therefore these treatments would be appropriate for initial treatment. The clinical evidence review did not specifically look for evidence of the timing of treatment escalation. Some studies reported the proportion of patients changing treatment but not in sufficient detail to be able to accurately model an intensification pathway and they mostly reported escalation to insulin. All interventions in the model were recommended at an earlier line than insulin and thus including this evidence in the model would be unlikely to alter recommendations. The clinical inputs into the model were based on intention-to-treat principles and should therefore match what would be expected if intensification had been modelled. As we did not specifically model intensification and outcomes from the NMA would be potentially reflect outcomes for a pathway of drugs it may underestimate the incremental cost of some interventions. We have noted this as a limitation of the model in the report.

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				there have been recommendations to add further treatments throughout the guideline for patients who fail to reach their glycaemic targets or who develop ASCVD. As such, the simplified model approach does not adequately reflect the clinical pathway recommended in the guideline. Summary AstraZeneca recommend that the economic model should incorporate a clear intensification algorithm representative of the draft guideline pathway, reflecting clinical practice and ensuring transparency. This approach would ensure the modelling is well aligned with the recommended clinical pathway and is therefore more likely to effectively inform and guide the recommendations presented in the guideline.	The inclusion of treatment intensification would bring with it the need to make simplifying assumptions around the intensification pathway and add further structural uncertainty.
Betsi Cadwaladr University	Consultation questions		001	<i>Would it be challenging to implement any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives).</i> The main challenge would be getting the recommendations approved and funded as they are outside of the current NICE technology appraisals	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.

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				and therefore the answer to question 3 will help with this.	
Betsi Cadwaladr University	Consultation questions		002	<i>Would implementation of any of the draft recommendations have significant cost implications?</i> Yes the recommendations will have significant cost implications. Less so for the SGLT-2 inhibitors now that dapagliflozin has lost its patent but for the GLP-1 receptor agonists it will have significant financial implications. The additional reviews of patients will also have financial implications.	Thank you for your comment.
Betsi Cadwaladr University	Consultation questions		003	<i>Should NICE update the existing technology appraisals for canagliflozin, dapagliflozin, empagliflozin, and ertugliflozin (TA288, TA315, TA336, TA390, TA418, TA572, TA583)? If so, please provide a rationale for this. Details of the update process are in NICE health technology evaluations: the manual, see 8.4 Surveillance decision options.</i> Yes NICE should update existing technology appraisals. We have a “pot” of money to fund NICE technology appraisals but we do not have a “pot” of money to fund NICE guidelines. Therefore it would make it much easier to enable these recommendations to be added to formulary and	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.

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				funding approved so that we can focus on education and training of clinicians to ensure patients on the ground receive the best treatment as per these new guidelines, without the delay that would be the case if falls under guideline commissioning arrangements. If the technology appraisals are not updated it will lead to a lengthy non-guaranteed process of building a business case of a cash strapped organisation to agree to fund the recommendations within the guideline.	
Betsi Cadwaladr University	Guideline	General		Felt much of the guideline is vague and lacks clarity	Thank you for your comment. We have changed some wording to add clarity.
Betsi Cadwaladr University	Guideline	005	004	In NG 5 Overweight and obesity management: 1.1 General principles: 1.1.1 – 1.1.6 “Before or during any discussions, think about the wider determinants and the context of overweight and obesity” it is not clear how a HCP can think about these things, without also discussing with the individual. I agree these areas are essential to offering any weight management/dietary support, however it takes time and trust. .1.4 Record the outcome of the discussion to ensure that subsequent healthcare professionals are aware that the matter has been raised, and know about the person's views and any actions already taken to manage overweight or obesity. What if records are not shared across multi professions? What if raised in other morbidities for	Thank you for your comment. This draft guideline consultation was to update the Type 2 Diabetes guideline for medicines. The recommendations from the Overweight and obesity management guideline (NG 246) published in January 2025 were not part of this consultation.

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				example renal cardiac, orthopaedic context 1.1.7 Equipment – “equip specialist settings with suitable seating and monitoring equipment” – in primary care settings is this feasible /budgeted for?	
Betsi Cadwaladr University	Guideline	005	010	These guidelines are focused on insulin treated Type 1 individuals – an insulin treated Type 2 is more likely have an eating disorder which is linked to binge eating disorder and overweight /obesity. There is no guidance for this in the NG 13. A type 2 person on insulin therapy who develops anorexia or bulimia is likely to reduce weight and therefore not require insulin.	Thank you for your comment. This is an important area of note. This is outside of the scope of the guideline update. We will highlight this with the surveillance team as a gap in the current guidance.
Betsi Cadwaladr University	Guideline	007	013	The NICE guideline Overweight and Obesity management 1.16.8 The guidelines for Low calorie diet recommend a supportive team for Type 2 diabetes. For very low calorie diets however, the overweight & obesity management is focused on high body mass index /pre surgery and via specialist weight management service. The accompanying information on how the committee made this recommendation is far more nuanced that the link to the NICE guideline on Overweight and obesity. It does also rightly explain the complexities of the longer term counselling /training for healthcare professionals. In addition, this guideline notes the potential deprescribing of medication on very low calorie diet – however, for Type 2 individuals this needs to be more prominent	Thank you for your comment. The dietary advice section of the type 2 diabetes guideline (NG28) was out of scope for this medicines update. However, We have added a recommendation in the ‘Involving people in medicine discussions’ section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A cross-reference link has been added to the NHS Pathways to Remission programme which can be used to access eligibility and referral thresholds.

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				and dynamic prescribing and or alternative prescribing – so really needs a prescribing healthcare professional/dietitian to manage safely in primary care	A cross reference has also been added to recommendations on low-energy and very-low-energy diets to achieve type 2 diabetes remission which was considered as part of the update of the overweight and obesity management guideline (NG 246).
Betsi Cadwaladr University	Guideline	010	019	<i>To reinforce advice about diet</i> – what does reinforce mean really, in context of the earlier new 2025 recommendations re wider drivers of obesity etc? Could be counterproductive. Although in principle this is necessary, there needs to be consideration to the time, skill set and also where resource and capacity may be reallocated i.e. from weight management service to diabetes primary care services for example	Thank you for your comment. This section was amended for updating language only and was out of scope for this guideline update. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
Betsi Cadwaladr University	Guideline	016	007	Is the care plan a patient plan – is this in place in Wales? How often should this be updated? Will all individualised prescribed an SGLT-2 inhibitor have a supply of blood ketone strips? Is this funded and how will the expiry date be monitored? Does the individual have a carer /partner who also may be informed?	Thank you for your comment. This is not a specific document, but each person has a treatment plan written for them when they are seen by a healthcare professional as an inpatient and on discharge. This is in place in Wales as England. This should be updated when it needs to be updated dependent on the person's needs. We have not conducted an evidence review into whether people prescribed an SGLT-2 inhibitor need to have ketone strips and cannot comment on this. The carer or partner or both should only be informed if the person consents for them to be, or if there is a legal reason why they should be informed.

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Betsi Cadwaladr University	Guideline	016	015	Include "advise to seek advice from healthcare professional on adjustment of insulin or oral medication if unsure"	Thank you for your comment. These recommendations are for healthcare professionals, who should use them in their work together with their own judgement and discussion with people using services.
Betsi Cadwaladr University	Guideline	018	001	Clarity is this based on QRISK? Does this recommendation suggest that anyone with diabetes will go on SGLT-2 inhibitor and metformin or those with QRISK > 10%?	Thank you for your comment. This is referring to anyone with type 2 diabetes, rather than referring to QRISK.
Betsi Cadwaladr University	Guideline	019	009	Would we still prescribe semaglutide if the patient had a low BMI	Thank you for your comment. The BNF states the side effects of decreased appetite and decreased weight for semaglutide. Therefore, these side effects should be taken into consideration when assessing a person's requirements and decided if it is an appropriate medicine or not (for example a person living with underweight). The committee have made a recommendation in the "Reviewing other medicines" section to recommend stopping GLP-1 receptor agonists or tirzepatide if the person taking it becomes underweight (BMI under 18.5 kg/m ²).
Betsi Cadwaladr University	Guideline	019	009	If someone is unable use subcutaneous semaglutide could they be offered an alternative GLP-1 agonist? Either oral semaglutide (Rybelsus) or different GLP-1 agonist or GLP-1/GIP (tirzepatide)	Thank you for your comment. The committee concluded that they should not be offered as on reviewing the evidence for clinical and cost-effectiveness only subcutaneous semaglutide showed sufficient evidence of cardiovascular and renal protection and glycaemic benefits alongside a potentially beneficial weight reduction side effect while also being cost effective. While liraglutide was cost effective, it was not clinically effective in the same way. Therefore, of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide has been offered for people in this population.

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Betsi Cadwaladr University	Guideline	019	009	There are concerns around drug shortages again if mentioning one specific GLP-1 receptor agonist.	Thank you for your comment. NICE makes recommendations based on clinical effectiveness and cost-effectiveness evidence. Subcutaneous semaglutide was the only GLP-1 receptor agonist that showed clinically important evidence of cardiovascular and renal protection and glycaemic benefits alongside a potentially beneficial weight reduction side effect while also being cost effective for people with atherosclerotic cardiovascular disease; therefore, the committee did not recommend other drugs in this class.
Betsi Cadwaladr University	Guideline	019	009	Is the initiation of semaglutide regardless of BMI? Does the patient have to have a specific BMI for this to be initiated?	Thank you for your comment. The BNF states the side effects of decreased appetite and decreased weight for semaglutide. Therefore, these side effects should be taken into consideration when assessing a person's requirements and decided if it is an appropriate medicine or not (for example a person living with underweight). Therefore there is no BMI threshold as this is not a recommendation that requires one. Subcutaneous semaglutide is being recommended for cardiovascular and renal protection and glycaemic benefits. This wording has been added to the recommendation.
Betsi Cadwaladr University	Guideline	020	005	Does this include tirzepatide or only GLP-1 only on receptor agonists?	Thank you for your comment. This has been changed to "GLP-1 receptor agonist or tirzepatide" to include tirzepatide.
Betsi Cadwaladr University	Guideline	020	005	Is this any GLP-1 receptor agonist including oral semaglutide and GLP-1/GIP (tirzepatide)	Thank you for your comment. This has been changed to "GLP-1 receptor agonist or tirzepatide" to include tirzepatide.
Betsi Cadwaladr University	Guideline	020	014	As GLP-1 receptor agonists are beneficial for weight reduction why aren't they recommended here in addition to SGLT-2 inhibitor and metformin	Thank you for your comment. The committee recommended initial treatment with an SGLT-2 inhibitor in addition to metformin because of the cardiovascular and renal protective

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					benefits of SGLT-2 inhibitors. The committee discussion highlights the committee's experience that it is possible for people to have marked improvements in weight with an SGLT-2 inhibitor and metformin. Therefore, GLP-1 receptor agonists or tirzepatide should only be added at least 3 months after initial treatment with metformin and an SGLT-2 inhibitor, which is covered in recommendations on treatment options if further medicines are needed. If the person's glycaemic targets have not been met, then there is a consider recommendation around using triple therapy with a GLP-1 receptor agonist or tirzepatide. If the person's weight targets have not been met, then this is outside the scope of this guideline, and users should refer to NICE's guideline on Overweight and obesity management [NG246] .
Betsi Cadwaladr University	Guideline	021	010	Some advice on doses of metformin - as dose reduction is required for eGFR < 45 ml/min/1.73 m ²	Thank you for your comment. The committee agreed that people with an eGFR above 30 ml/min/1.73 m ² should see the same benefits from diabetes medicines as people without chronic kidney disease. They agreed that for people with an eGFR less than 30 ml/min/1.73 m ² , metformin should not be prescribed. Please refer to the rationale and impact section of the guideline and the committee discussion for further details. We appreciate your point however, these points are discussed in the BNF and SPC. Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for prescribed medicines. These are explained in the SPC for the medicine or the British National Formulary (BNF). This applies to all medicines for NICE

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					guidelines and so recommendations do not state this information.
Betsi Cadwaladr University	Guideline	021	011	As there will be little reduction in HbA1c/blood sugars in patients with an eGFR of < 45 ml/min/1.73 m ² is it not worth mentioning this as it is being recommended to use alone in this group of patients – realise they will derive benefit from a CKD perspective but unlikely to control blood sugars so would need additional therapy at this point – is it worth including this information here.	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .
Betsi Cadwaladr University	Guideline	021	011	State stop metformin if eGFR < 30 ml/min/1.73 m ²	Thank you for your comment. The committee agreed that people with an eGFR above 30 ml/min/1.73 m ² should see the same benefits from diabetes medicines as people without chronic kidney disease. They agreed that for people with an eGFR less than 30 ml/min/1.73 m ² , metformin should not be prescribed. Please refer to the rationale and impact section of the guideline and the committee discussion for further details. We appreciate your point however, these points are discussed in the BNF and SPC. Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any

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					monitoring requirements for prescribed medicines. These are explained in the SPC for the medicine or the British National Formulary (BNF). This applies to all medicines for NICE guidelines and so recommendations do not state this information.
Betsi Cadwaladr University	Guideline	022	001	Why is GLP1s receptor agonist not listed as a consideration for chronic kidney disease patients, especially those with lower eGFR. There is growing evidence for their use in patients with chronic kidney disease.	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Betsi Cadwaladr University	Guideline	023	013	When would it be clear that metformin is tolerated and so an SGLT2i can be added in?	Thank you for your comment. We have added a statement to clarify this is when the maximum tolerated dose is achieved for both metformin and SGLT-2 inhibitors.
Betsi Cadwaladr University	Guideline	023	013	Would be useful here to mention that SGLT-2 inhibitor should not be started if HbA1c is above 85 mmol/mol and this must first be controlled before initiating SGLT-2 inhibitor	Thank you for your comment. The committee considered adding advice about SGLT-2 and people with high baseline glucose levels. They ultimately agreed that the problem in this scenario is more about managing the causes of the adverse events, such as dehydration and volume depletion, that can increase the risk of events such as diabetic ketoacidosis.

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					Given this, they then updated the recommendations in the section about "Preventing diabetic ketoacidosis when taking SGLT-2 inhibitors" to give warning about this. They acknowledged that while a high baseline HbA1c can be a concern for starting an SGLT-2 inhibitor, it was not an absolute contraindication, and each case should be considered on a case by case basis.
Betsi Cadwaladr University	Guideline	025	014	What target? previous iterations of NICE guidance specified what target, it is concerning that no target has been specified – concern that there is no real specification of what HbA1c level/weight you would start and what HbA1c/weight you would stop – there is a risk that lots of patients will continue on these expensive drugs without sufficient benefit – can we have some guidance as to what would be a cost effective improvement.	Thank you for your comment. Wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes.
Betsi Cadwaladr University	Guideline	025	014	What targets? Are these personalized targets, or as per current NG28 weight loss and HbA1c reduction at 6 months as specified?	Thank you for your comment. Wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes.
Betsi Cadwaladr University	Guideline	025	016	If patient not deriving benefit from the GLP-1 receptor agonist from a glycaemic/weight management side of things what dose of GLP-1 receptor agonist would you prescribe to continue to receive the atherosclerotic cardiovascular disease benefits? What would be the most cost effective	Thank you for your comment. If the person does not have atherosclerotic cardiovascular disease or early onset type 2 diabetes, then GLP-1 receptor agonist or tirzepatide treatment would be stopped if it did not help them to reach their glycaemic target. The committee agreed that the optimal approach for doses would be to support people to reach the maximum tolerable dose for all treatments included in the

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				dose to prescribe to maintain atherosclerotic cardiovascular disease benefits?	review. Given this, it was agreed to analyse all doses together in the protocol and to not do a prespecified subgroup analysis based on this. Therefore, it is not possible, while maintaining methodological rigour, to determine the most cost-effective dose of GLP-1 receptor agonist or tirzepatide to use.
Betsi Cadwaladr University	Guideline	027	002	If someone is unable use subcutaneous semaglutide could they be offered an alternative GLP-1 agonist? Either oral semaglutide (Rybelsus) or different GLP-1 agonist or GLP-1/GIP (tirzepatide)	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
Betsi Cadwaladr University	Guideline	027	008	Is GLP1 not recommended in people with heart failure with reduced ejection fraction?	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.

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Betsi Cadwaladr University	Guideline	027	011	Why are DPP4i's not recommended in heart failure?	Thank you for your comment. DPP-4 inhibitors were not recommended previously due to the recommendation for semaglutide being present (given we had recommended that people should not be prescribed a DPP-4 inhibitor and a GLP-1 receptor agonist at the same time). This recommendation has subsequently been removed. Therefore, DPP-4 inhibitors have been added in.
Betsi Cadwaladr University	Guideline	028	004	Is this regardless of patient's weight?	Thank you for your comment. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. These effects may not be beneficial for everyone, and this should be taken into account by the prescriber. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. An additional recommendation has been added to stop GLP-1 receptor agonist or tirzepatide treatment if someone becomes underweight during treatment. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in

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					Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Betsi Cadwaladr University	Guideline	029	011	For clarity as there are different doses/preparations for prescribing GLP-1s for T2D and weight management – we are querying whether we would be prescribing for type 2 diabetes or for weight management and therefore which dose or preparation we would be prescribing – some clarity here would be helpful.	Thank you for your comment. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. Given this, the doses and preparations for type 2 diabetes should be used when using the type 2 diabetes guideline recommendations.
Betsi Cadwaladr University	Guideline	030	013	Could there be some clarity on where tirzepatide is recommended? Is it only as per the NICE technology appraisal or is it also included where	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist and tirzepatide" to show the role of tirzepatide in this population.

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				GLP-1 receptor agonist is recommended in the guideline?	
Betsi Cadwaladr University	Guideline	031	019	People with frailty may have heart failure so this should be considered before considering pioglitazone.	Thank you for your comment. As information relating to fluid retention and heart failure is covered in the drug's SPC, the committee decided that it was not necessary to revisit this recommendation. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Betsi Cadwaladr University	Guideline	032	020	When initiating insulin 'stop any other medicines being used solely to manage hyperglycaemia ' could be confusing -does it mean stop gliptin / Sulfonyurea?	Thank you for your comment. The committee highlight the risk that sulfonylureas and insulin-based treatments have in causing hypoglycaemia and falls. For this population, the committee consider it important that the smallest effective number of treatments are being used at the lowest effective dose to reduce the impact on their quality of life. However, the therapy for each person should be considered on a case-by-case basis and may include halting gliptins or sulfonylureas.
Betsi Cadwaladr University Health Board	Guideline	020	013	What is being classed as suffering from obesity? Is it as per the NICE TAs for GLP-1 receptor agonists weight management, or is it as per previous NICE	Thank you for your comment. The sections on initial medicines and treatment options if further medicines are needed for people living with obesity now include cross-references to

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				guidance >35kg/m2, or is it class one obesity > 30kg/m2? Some clarity/definition would be helpful	recommendations on classifying overweight and obesity in NICE's guideline on overweight and obesity management.
Boehringer	General	General		Boehringer Ingelheim appreciates the opportunity to comment on the draft guideline. We welcome the committee's decision-making process, which took into account clinical and cost-effectiveness evidence, relevant NICE technology appraisals (TAs), regulatory licensing status, clinical experience, and considerations on health inequalities. This led to the first-line recommendation of empagliflozin and other SGLT-2 inhibitors with metformin for all clinically appropriate type 2 diabetes mellitus (T2DM) populations. We particularly welcome the committee's emphasis on holistic health improvements, including cardiovascular (CV) and renal protection as primary goals alongside glycaemic control. We also support the integration of these priorities into the economic analysis, which moved beyond HbA1c-based intensification to directly model cardio-renal protection. We note as a strength of the economic evaluation the inclusion of subgroup analyses aligned with the comorbid T2DM populations for which the committee made tailored recommendations.	Thank you for your comments. Any specific comments relevant to specific sections will be considered in those sections. The committee have reviewed about whether additional information regarding target values for blood tests are required and decided these were not required. Any guidance relevant to conditions that are cross-referenced in this guideline (for example: Chronic Kidney Disease) are relevant to this guideline.

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				Overall, while the guidance provides a clear overview for managing people with T2DM across the comorbidity spectrum, it would benefit from additional clarity on prescribing responsibilities and tools to aid patient identification (as included in other guidelines). Finally, we encourage NICE to continue to review T2DM and related comorbidity guidelines, such as chronic kidney disease (CKD), to ensure alignment with these evolving therapeutic areas and wider NHS policy changes.	
Boehringer	Guideline	General		Given the NHS's long-term focus on prevention and early intervention in chronic conditions such as T2DM and CV disease, we believe it would be valuable for the guideline to reflect this direction and ambition. The guideline should also align with the <i>Fit for the future: 10 Year Health Plan for England</i> , including the role of local neighborhoods in prescribing areas of shared care, a greater emphasis on digital access for patients and staff, and greater integration of care between primary and secondary settings.	Thank you for your comment. The guideline has integrated elements of the 10 Year Plan into the nature of the policy where it is within the scope to do so. These areas raised in this comment are outside of the scope of this update which focused on medicines for type 2 diabetes.
Boehringer	Committee Discussion	014 - 040		Section 1.2.3 Boehringer Ingelheim acknowledges the first line recommendation of SGLT-2 inhibitors in T2DM adults with atherosclerotic cardiovascular disease (ASCVD) based on the committee's overall approach to decision-making. We would like to highlight an inconsistency between the discussion	Thank you for your comment. We appreciate your feedback. Although there was uncertainty around the effectiveness of all the SGLT-2 inhibitors for the outcome of non-fatal stroke, empagliflozin was the only SGLT-2 inhibitor where the point estimate for the hazard ratio was greater than 1. Considering that the hazard ratio was 1.24 (95% CrI 0.92, 1.65), with the point estimate and lower credible interval substantially higher

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				paper and the accompanying ASCVD NMA report (document F9). On page 14 of the discussion paper, the committee noted that: <i>"All the SGLT-2 inhibitors showed benefits in reducing individual cardiovascular events (with the exception of empagliflozin in reducing the number of strokes based on one study)."</i> However, the F9 NMA report (page 44, lines 12–14, Table 22) states that: <i>"The evidence for ..., dapagliflozin, empagliflozin and ertugliflozin was uncertain, with the 95% credible intervals (CrI) for these treatments including the probability of both protective and harmful effects relative to placebo (Table 22)".</i> The committee also acknowledged this uncertainty on page 40 of the discussion paper, noting that <i>"There was limited data for both non-fatal stroke and unstable angina, with no evidence of a difference in effectiveness seen for any intervention included in either analysis."</i> We believe the interpretation of the evidence as presented on page 40 of the discussion paper is more accurate and consistent based on the NMA report. We therefore respectfully request that the statement on page 14 is rephrased to reflect the available evidence as follows: <i>"All the SGLT-2 inhibitors showed benefits in reducing individual cardiovascular events (with the exception of non-</i>	than the other SGLT-2 inhibitors, it was decided that this finding should be noted. When considering the NMA evidence, the committee considered the direction of effect even when results had a small effect (when the credible intervals crossed zero) giving a more definitive rating of a large effect when the credible intervals predicted a more likely result in either direction. Therefore, on one hand they would state that all SGLT-2 inhibitors showed a beneficial effect, but also that the effect was uncertain where imprecision was present in estimating the effect estimate. The health economic modelling was deterministic and did not take imprecision into account, meaning that the cost-effectiveness was not influenced by the uncertainty around the point estimates.

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				<i>fatal strokes and unstable angina for which the evidence was uncertain).</i> "	
Boehringer	Committee Discussion	029-031 038-039		Sections 1.5.1 and 1.5.4.2 We would like to highlight an additional limitation of the evidence base, as the EMPEROR-Preserved¹ and EMPEROR-Reduced² trials were not included in the review and synthesis of clinical effectiveness evidence. These RCTs demonstrated empagliflozin's benefit in reducing hospitalisation for heart failure (HHF) versus placebo across the ejection fraction spectrum in people with heart failure (HF). Importantly, the reduction in HHF was also shown in the T2DM subgroups, which represented approximately half of each trial's participants^{1,2}. We note that the committee acknowledged this limitation in its discussion (pages 29–31 and 38–39) and recognised the EMPEROR trials as significant studies in people with HF. The committee also referred to the relevant NICE TAs for empagliflozin and dapagliflozin in HF with reduced ejection fraction (TA773³ and TA679⁴, respectively) and preserved ejection fraction (TA929⁵ and TA902⁶, respectively). Drawing on their clinical experience, knowledge of the excluded trials and existing NICE TAs, the committee concluded that SGLT-2 inhibitors provide important clinical benefits for people with T2DM and	Thank you for your comment. As you correctly point out, this is a limitation of the review that was highlighted in the committee discussion document. Both the EMPEROR-Preserved and EMPEROR-Reduced trials were not included in our clinical evidence review as the study populations included people with and without type 2 diabetes. We have now included a recommendation for the use of any SGLT-2 inhibitors for people with eGFR above 30 ml/min/1.73² while only dapagliflozin and empagliflozin are recommended for people with an eGFR between 20 ml/min/1.73m² and 30 ml/min/1.73m². This is based on the medicines cardiovascular and renal benefits rather than their application in reducing HbA1c. For people in the latter group, a DPP-4 inhibitor has also been added to provide support in reducing HbA1c. The summary for product characteristics for canagliflozin and ertugliflozin states that there is limited experience of use in people with heart failure, while the sections about renal impairment states specifically about eGFR values when different agents should not be initiated. Therefore, the committee agreed that different recommendations should be made in this specific circumstance for this guideline.

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				HF and are already regularly prescribed in this setting. They therefore made a first-line recommendation for SGLT-2 inhibitors with metformin for people with T2DM and HF. We believe this recommendation highlights the value of the committee's overall approach to decision-making and we acknowledge the inclusion of empagliflozin and other SGLT-2 inhibitors as first-line treatment in this population. We would, however, appreciate clarification on the rationale for recommending SGLT-2 inhibitors at class level for people with T2DM and HF, rather than limiting the recommendation to the licensed options empagliflozin and dapagliflozin, consistent with the CKD population. <u>References</u> 1. Filippatos G, Butler J, Farmakis D, Zannad F, Ofstad AP, Ferreira JP, et al. Empagliflozin for Heart Failure With Preserved Left Ventricular Ejection Fraction With and Without Diabetes. <i>Circulation</i>. 2022;146(9):676-86. 2. Anker SD, Butler J, Filippatos G, Khan MS, Marx N, Lam CSP, et al. Effect of Empagliflozin on Cardiovascular and Renal Outcomes in Patients With Heart Failure by	

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				Baseline Diabetes Status. Circulation. 2021;143(4):337-49. 3. NICE. Empagliflozin for treating chronic heart failure with reduced ejection fraction (2022). NICE technology appraisal guidance 773 [Available from: https://www.nice.org.uk/guidance/ta773]. 4. NICE. Dapagliflozin for treating chronic heart failure with reduced ejection fraction (2021). NICE technology appraisal guidance 679 [Available from: https://www.nice.org.uk/guidance/ta679]. 5. NICE. Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction (2023). NICE technology appraisal guidance 929 [Available from: https://www.nice.org.uk/guidance/ta929]. NICE. Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction (2023). NICE technology appraisal guidance 902 [Available from: https://www.nice.org.uk/guidance/ta902].	
Boehringer	Committee Discussion	029-031		Section 1.5.1 We would like to highlight a limitation of the evidence base, as the EMPA-KIDNEY¹ trial was not included in the review and synthesis of clinical effectiveness evidence for this update. EMPA-	Thank you for your comment. As your correctly point out, this is a limitation of the review that was highlighted in the committee discussion document. It was agreed in development not to include T2DM subgroups from trials in the analysis as there may be potentially relevant studies that would not be identified

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				KIDNEY was an important RCT demonstrating the renal benefits of empagliflozin in people with CKD. In this trial, benefits were also shown in the T2DM subgroup, which represented approximately half of the trial participants. We note that the committee acknowledged this limitation in its discussion (pages 29–31) and recognised EMPA-KIDNEY as a significant study in CKD management. Despite this limitation, the committee considered the available clinical and cost-effectiveness evidence, the CKD licenses for SGLT-2 inhibitors and the corresponding NICE technology appraisals (TA942² and TA1075³). Based on these, they made a first-line recommendation of empagliflozin or dapagliflozin with metformin for people with T2DM and CKD with an estimated glomerular filtration rate (eGFR) of 20 mL/min/1.73 m² and above. We acknowledge this first-line recommendation and believe it reflects the strength of the committee's decision-making approach in improving outcomes for people with T2DM and CKD. <u>References</u> 1. The EMPA-KIDNEY Collaborative Group. Empagliflozin in Patients with Chronic Kidney Disease. New England Journal of Medicine. 2023;388(2):117-27.	in the literature searches. The EMPA-KIDNEY trial includes a mixed population with some people who had type 2 diabetes and some people who did not and therefore did not fall within the protocol for inclusion in the review. Thank you for your thoughts and we are glad you agree that this will help improve care for people with type 2 diabetes and chronic kidney disease.

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				2. NICE. Empagliflozin for treating chronic kidney disease (2023). NICE technology appraisal guidance 942 [Available from: https://www.nice.org.uk/guidance/ta942] NICE. Dapagliflozin for treating chronic kidney disease (2025). NICE technology appraisal guidance 1075 [Available from: https://www.nice.org.uk/guidance/ta1075].	
Boehringer	Visual summary	002		Boehringer Ingelheim considers that the visual summaries would benefit from additional clarity on renal function evaluation, consistent with the suggestions we have provided on the draft guideline. We therefore suggest clarifying that renal status assessment should include regular eGFR and uACR measurements prior to and following treatment initiation, with appropriate referral triggers to a nephrologist.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. We have a recommendation on renal status assessment in the guideline under "Assessing risks before starting medicines" and further details for SGLT2 inhibitor initiation under "Other factors the committee took into account" in the committee discussion.
Boehringer	Visual summary	002		Boehringer Ingelheim considers that the emphasis of the guideline on CV risk prevention would benefit from additional clarification in the visual summaries, for example through a visual aid specifying that CV status assessment should be undertaken as part of the annual review of people with T2DM.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. Additional information can be found in the guideline under "Reviewing medicines".
Boehringer	Guideline	017	002	Section 1.8.7 Boehringer Ingelheim welcomes the recommendation to assess CV and renal status, as well as the risk of developing CV disease, before selecting the most appropriate treatments for T2DM	Thank you for your comment. We agree that assessment of cardiovascular and renal status is important. We have cross referred to the chronic kidney disease guideline in this guideline which provides information about the blood tests required if this needed.

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				management. While the guideline includes specific measures for CV assessment, we believe additional clarity on assessing renal status would further reinforce the treatment goal of renal protection, in line with points raised by the committee in their discussion. In the discussion papers (page 44), the committee noted that people with CKD present with a range of risk categories requiring both eGFR and albumin to creatinine ratio (ACR) parameters for diagnosis. The committee also recognised that initiation of SGLT-2 inhibitors can cause an initial eGFR drop that typically recovers after three months, and therefore recommended monitoring renal function, including eGFR and ACR (page 60 in committee's discussion). In light of this, we suggest that the guideline explicitly recommends regular eGFR and urinary ACR (uACR) measurements prior to and following treatment initiation, with appropriate referral triggers to a nephrologist. This would align with the committee's stated objectives and strengthen the focus on renal protection in the updated guideline.	
Boehringer	Guideline	018	001	Section 1.8 Boehringer Ingelheim notes that the criteria for the order in which the different T2DM populations are listed in the guideline are not clear. For consistency, we suggest that the populations are presented in alphabetical order.	Thank you for your comment. All recommendations for the different populations are labelled with headings so as to be identified easily. We have chosen to start the recommendations for those people with no significant morbidity as this states the main principle of treatment (that most people should be prescribed SGLT-2 inhibitors and metformin for

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					cardiovascular and renal protection and glycaemic benefits), which is important for interpretation of the guideline if reading it from start to finish. The populations for people with chronic kidney disease and people with frailty have circumstances where treatment may not fit this principle requiring changes from the standard treatment and so they have been placed at the end. When the guideline is published on NICE's website, it will have links to each section which will aid users to navigate to relevant sections. .
Boehringer	Guideline	021	009 016-017	Sections 1.8.24 and 1.8.26 Boehringer Ingelheim acknowledges the introduction of eGFR stratification in the assessment of clinical effectiveness evidence and treatment recommendations for people with T2DM and CKD. We believe that additional guidance on CKD risk stratification would be valuable, as renal benefits and eGFR-based treatment decisions are key aspects of this update. We would also like to highlight the important role of uACR in assessing renal status and guiding treatment decisions in people with CKD. We therefore suggest including recommendations for regular eGFR and uACR monitoring in clinical practice, as required through the Diabetes 9 key care processes, together with appropriate referral triggers to a nephrologist. We believe that incorporating these recommendations in the	Thank you for your comment. The scope of this update was limited to medicines for type 2 diabetes, and therefore recommendations around eGFR stratification are out of scope. However, the recommendations on initial medicines in people with type 2 diabetes and chronic kidney disease reference NICE's guideline on chronic kidney disease [NG203], where it is recommended that people with diabetes are offered testing for CKD using eGFR creatinine and ACR.

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				guideline would strengthen the focus on renal protection and align with the guideline's holistic approach to T2DM management.	
Boehringer	Guideline	049	006	Boehringer Ingelheim believes this section would benefit from additional guidance on assessing renal status, including recommendations for regular eGFR and uACR monitoring, as required through the Diabetes 9 key care processes. We suggest that these be accompanied by appropriate referral triggers to a nephrologist.	Thank you for your comment. The guideline cross refers to NICE's guideline on chronic kidney disease which discusses what is involved in assessment of chronic kidney disease.
Boehringer	Committee Discussion	056	1.6.3	Section 1.6.3 Regarding the economic analysis, the committee stated on page 56 of the discussion papers that: <i>"The SGLT-2 inhibitor class was also marginally above the cost-effectiveness value at which NICE typically recommend interventions when the background treatment costs of cardiovascular events were set to zero."</i> We would like to highlight that the economic analysis report (page 61, lines 20–21, and page 62, Table 49) shows that the sensitivity analysis with subsequent CVD costs set to zero resulted in an incremental cost-effectiveness ratio (ICER) of £14,360 per quality-adjusted life year (QALY) gained for SGLT-2 inhibitors. As this figure is below the £20,000 per QALY cost-effectiveness threshold, we respectfully request that the statement on page	Thank you for your comment. We have updated both the analysis and the commentary in the economic analysis to account for the latest drug prices. The SGLT-2 inhibitor class now has an ICER below the cost-effectiveness value at which NICE typically recommend interventions (£20,000 per QALY gained) in both the base case analysis and the sensitivity analysis where the background treatment costs of cardiovascular events were set to zero.

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				56 is corrected to: <i>"The SGLT-2 inhibitor class was also below the cost-effectiveness value at which NICE typically recommends interventions when the background treatment costs of cardiovascular events were set to zero."</i>	
Boots UK	Guideline	General		- Boots fully support the proposed changes given the patient clinical benefits expected. - An initial analysis of 1,082 anonymous Type 2 diabetes patient medication records from 5 representative Boots pharmacies in England showed that there would be significant increases in pharmacy team workload to support implementation. - Projecting this incremental work to market level in England, we estimate the following net additional investment will be needed - The changes will result in an additional 13.4m items per annum to be dispensed. At the current single activity fee of £1.46 this will require additional funding to the Community Pharmacy Contractual Framework (CPCF) of £19.6m per annum - Patients having their therapy changes will also qualify for the New Medicines Service (NMS) which will greatly support their	Thank you for your comment. We appreciate your feedback.

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				uptake of new treatment regimens and ensure that the benefits envisaged are realised. Boots analysis shows that these changes will increase NMS interventions by 1.275m per annum. At current CPCF tariff, this requires investment in the CPCF of £17.9m ○ At October 2025 drug tariff medicines reimbursement prices, the projected net impact on medicines costs will be c£800m per annum. To enable pharmacies to make the necessary investment in these increased medicines costs, the permitted margin retained by contractors will need to be proportionally increased by £80m • It is our conclusion that for the clear and significant health benefits of the NICE proposals to be realised, investment of c £119m into the national CPCF is required to enable pharmacy contractors finance the sourcing of the medicines required, manage the increased dispensing workload, and deliver the recognised and validated NMS support interventions to maximise patient clinical outcomes.	

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Breastfeeding Network	Visual summary	general		This visual summary makes no mention of considering the possibility of pregnancy or breastfeeding in people of childbearing potential. As this comprises a significant proportion of the population, and has a significant impact in treatment choices, or the need to ensure pregnancy prevention is in place, these considerations should be acknowledged here.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about pregnancy or breastfeeding, users should refer to the rationale and impact sections of the guideline. Additionally, the guideline cross-refers to the NICE guideline on diabetes in pregnancy if a person is pregnant or planning to become pregnant.
Breastfeeding Network	Guideline	041-043	General (research recommendations)	We suggest an additional recommendation for research, into the safety of use of GLP-1 receptor agonists in breastfeeding. Recently updated MHRA guidance states that " <i>GLP-1 medicines should not be taken by people who are breastfeeding. This is because there is not enough safety data to know whether taking a GLP-1 medicine can cause harm to the baby.</i> " Whilst it is very important that breastfeeding parents do not take any medicines that might cause harm, withholding medicines that could convey significant benefit due to a lack of information on safety indicates that research is urgently needed to provide this information. Prior to the MHRA guidance released in June 2025 cited above, we understood that although not licenced for use in breastfeeding, GLP-1 medicines could be used in breastfeeding with caution and careful monitoring. We are concerned that this current position is overly risk averse and does not take into	Thank you for your comment. We did not undergo an evidence review into the safety of GLP-1 receptor agonists in people who are breastfeeding and therefore we cannot make a research recommendation in this area (as we cannot confirm whether evidence already exists in this area).

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				account all available information regarding these medicines specifically, use of medicines in breastfeeding in general, and the risks of not breastfeeding, to mother and child, in order to take a medicine. We strongly advocate for more research into the impact of these medicines in breastfeeding, to ensure breastfeeding parents are not denied medicines which could convey significant benefit or encouraged to stop breastfeeding unnecessarily in order to take them. Please see our factsheet on diabetes and breastfeeding for further information: https://www.breastfeedingnetwork.org.uk/factsheet/diabetes/ https://www.gov.uk/government/publications/glp-1-medicines-for-weight-loss-and-diabetes-what-you-need-to-know/glp-1-medicines-for-weight-loss-and-diabetes-what-you-need-to-know#glp-1-medicines-and-breastfeeding	
Breastfeeding Network	Guideline	015	020-021	Suggest amend to "...what MHRA guidance says about the use of GLP-1 medicines in pregnancy <i>and breastfeeding</i>". People of childbearing potential may either be planning to breastfeed after pregnancy, which should be taken into account when planning treatment, or be currently breastfeeding (bearing in mind that breastfeeding is	Thank you for your comment. We have added breastfeeding into the recommendation.

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				recommended for children up to the age of two and beyond, and natural term breastfeeding can continue to at least the age of seven). A link could be included to section 1.6 of NG3: Diabetes in pregnancy: management from preconception to the postnatal period, Postnatal care, which covers blood glucose control, medicines and breastfeeding. We suggest healthcare professionals and patients could refer to our factsheet "Diabetes and Breastfeeding" (https://www.breastfeedingnetwork.org.uk/factsheet/diabetes/) for more information. They should also contact the UK drugs in lactation service, provided by the NHS specialist pharmacy service, (UKDILAS, https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-advice-contact-details/breastfeeding-medicines-advice-service/). Breastfeeding has significant health benefits for both breastfeeding parent and child, including reduction in risk of diabetes, so it is essential that conversations regarding treatment seek to protect breastfeeding wherever possible, whilst also optimising treatment.	

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				Victora CG, Bahl R, Barros AJ, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. <i>Lancet</i>. 2016;387(10017):475-490. doi:10.1016/S0140-6736(15)01024-7 https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/maternal-health-research/maternal-health-research-obesity/#:~:text=This%20observational%2030%2Dyear%20study,or%20more%20months%20of%20lactation.	
Breastfeeding Network	Guideline	018	Box at top	Suggest amend to “precautions to take in pregnancy <i>and breastfeeding</i>”. A link could be included to section 1.6 of NG3: Diabetes in pregnancy: management from preconception to the postnatal period, Postnatal care, which covers blood glucose control, medicines and breastfeeding. We suggest healthcare professionals and patients could refer to our factsheet “Diabetes and Breastfeeding” (https://www.breastfeedingnetwork.org.uk/factsheet/diabetes/) for more information. They should also contact the UK drugs in lactation service, provided by the NHS specialist pharmacy service, (UKDILAS, https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-advice-contact-details/breastfeeding-medicines-advice-service/)	Thank you for your comment. We have added breastfeeding to this box.

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				Breastfeeding has significant health benefits for both breastfeeding parent and child, including reduction in risk of diabetes, so it is essential that conversations regarding treatment seek to protect breastfeeding wherever possible, whilst also optimising treatment. Victora CG, Bahl R, Barros AJ, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. <i>Lancet</i>. 2016;387(10017):475-490. doi:10.1016/S0140-6736(15)01024-7 https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/maternal-health-research/maternal-health-research-obesity/#:~:text=This%20observational%2030%2Dyear%20study,or%20more%20months%20of%20lactation	
Breastfeeding Network	Guideline	026	002, box	Suggest amend to “precautions to take in pregnancy <i>and breastfeeding</i>”. A link could be included to section 1.6 of NG3: Diabetes in pregnancy: management from preconception to the postnatal period, Postnatal care, which covers blood glucose control, medicines and breastfeeding. We suggest healthcare professionals and patients could refer to our factsheet “Diabetes and	Thank you for your comment, this has been added.

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				Breastfeeding” (https://www.breastfeedingnetwork.org.uk/factsheet/diabetes/) for more information. They should also contact the UK drugs in lactation service, provided by the NHS specialist pharmacy service, (UKDILAS, https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-advice-contact-details/breastfeeding-medicines-advice-service/) Breastfeeding has significant health benefits for both breastfeeding parent and child, including reduction in risk of diabetes, so it is essential that conversations regarding treatment seek to protect breastfeeding wherever possible, whilst also optimising treatment. Victora CG, Bahl R, Barros AJ, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. <i>Lancet</i>. 2016;387(10017):475-490. doi:10.1016/S0140-6736(15)01024-7 https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/maternal-health-research-obesity/#:~:text=This%20observational%2030%2DYear%20study,or%20more%20months%20of%20lactation	
Breastfeeding Network	Guideline	048	006-017	The committee should make recommendations based on safety in breastfeeding as well as	Thank you for your comment. Breastfeeding has been added to this section.

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				pregnancy in people of childbearing potential. Recently updated MHRA guidance currently states "GLP-1 medicines should not be taken by people who are breastfeeding. This is because there is not enough safety data to know whether taking a GLP-1 medicine can cause harm to the baby." https://www.gov.uk/government/publications/glp-1-medicines-for-weight-loss-and-diabetes-what-you-need-to-know/glp-1-medicines-for-weight-loss-and-diabetes-what-you-need-to-know#glp-1-medicines-and-breastfeeding We suggest healthcare professionals and patients could refer to our factsheet "Diabetes and Breastfeeding" (https://www.breastfeedingnetwork.org.uk/factsheet/diabetes/) for more information. They should also contact the UK drugs in lactation service, provided by the NHS specialist pharmacy service, (UKDILAS, https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-advice-contact-details/breastfeeding-medicines-advice-service/) Breastfeeding has significant health benefits for both breastfeeding parent and child, including reduction in risk of diabetes, so it is essential that conversations regarding treatment seek to protect	

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				breastfeeding wherever possible, whilst also optimising treatment. Victora CG, Bahl R, Barros AJ, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. <i>Lancet</i>. 2016;387(10017):475-490. doi:10.1016/S0140-6736(15)01024-7 https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/maternal-health-research/maternal-health-research-obesity/#:~:text=This%20observational%2030%2DYear%20study,or%20more%20months%20of%20lactation	
British Dietetic Association - Diabetes Special Interest Group	Guideline	005	010	It is welcome that reference is made to eating disorders in diabetes, however these links refer mainly to issues relating to type 1 diabetes as they focus on glucose management, ketones and insulin misuse. It would be important with type 2 diabetes to consider the impact of binge eating disorder is likely to be the most prevalent.	Thank you for your comment. This is an important area of note. This is outside of the scope of the guideline update. We will highlight this with the surveillance team as a gap in the current guidance.
British Dietetic Association - Diabetes Special Interest Group	Guideline	006	027	The lack of review of the dietary guidelines, especially as much of it is dated 2009 which appears to pre-date the original NG28 which was published in 2015 means that this document is outdated and out of step with national practice guidelines in the UK as set out by Diabetes UK in 2018, Europe and USA. This has been flagged up previously, but it appears that this is again focused	Thank you for your comment. This is out of scope for the guideline update. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A review

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				on being a medication review rather than being a review.	of low-calorie diets was conducted as a part of the overweight and obesity management guideline to support this work. This guideline is cross referred to in the diabetes guideline.
British Dietetic Association - Diabetes Special Interest Group	Guideline	007	011	It is most welcome to see the addition of low and very low diets linked to pathways to remission of type 2 diabetes. Although it links to relevant guidelines, the need for medication review and long term maintenance should be considered in this document as short bullet points so that these key aspects are not overlooked.	Thank you for your comment. This is out of scope for the guideline update. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
British Dietetic Association - Diabetes Special Interest Group	Guideline	007	015	This should refer to weight loss (where appropriate) and should also include an acknowledgement of the role of sleep.	Thank you for your comment. This section is out of scope for the guideline update.
British Dietetic Association - Diabetes Special Interest Group	Guideline	008	013	This is not in grey, but is dated 2015 – has this been updated or not, see initial comment about data inconsistency and how this section is out of step with evidence and practice.	Thank you for your comment. This section has not been updated but had refreshed wording to align with changes in language over time. No changes occurred that changed the meaning of the recommendation.
British Dietetic Association -	Guideline	015	029	It is very welcome to see reference to non-judgmental language, it is essential this is acknowledged earlier in the guideline especially	Thank you for your comment and your welcoming of the recommendation. If nutrition and risks associated with this come up in conversations about medication discussions then

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Diabetes Special Interest Group				linked to weight management and lifestyle and not just with respect to medication. Effect of medication on nutrition and risks associated with this should be included in this section.	they should also be discussed with non-judgemental language, as the current wording of the recommendation covers all medication discussions.
British Dietetic Association - Diabetes Special Interest Group	Guideline	047	021	The section on involving people in medication discussions should be extended to lifestyle aspects of diabetes management as these are impacted at least to the same degree by stigma as medication discussions.	Thank you for your comment. This guideline update is focussed on medicines and the rationale is focussed on this as a reflection of the work done.
British National Formulary	Guideline	018	005	Rec 1.8.10 We are seeking clarification about when to recommend modified-release metformin. Current guidelines NG28 recommend modified-release metformin if gastrointestinal side-effects are experienced with standard-release metformin, whereas this recommendation advocates modified-release metformin when there are concerns about adherence to standard-release metformin. Is the potential for non-adherence the only situation when a patient should switch from standard- to modified-release metformin?	Thank you for your comment. Following committee discussion, the committee agreed that modified release metformin would have better tolerance and subsequent adherence than standard-release metformin. Therefore, we have updated the recommendations to recommend modified-release metformin as first line for all people prescribed metformin.
British National Formulary	Guideline	020	009	Rec 1.8.20 This recommendation advises adding a GLP-1 receptor agonist to an SGLT-2 inhibitor if metformin is contraindicated or not tolerated, whereas licensed product information recommends GLP-1 receptor agonist as monotherapy when	Thank you for your comment. This recommendation relates to people with early-onset type 2 diabetes. The strong 'offer' recommendation for SGLT-2 inhibitors reflects the evidence showing that SGLT-2 inhibitors are most effective at reducing the risk of cardiovascular events. The committee noted that the

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				metformin is considered inappropriate due to intolerance or contraindications. We are seeking clarification on whether there would be any scenario in which a GLP-1 receptor agonist would be used alone for T2DM management.	population of people with early-onset type 2 diabetes is more likely to include people living with obesity, who may benefit from the weight loss effects of the GLP-1 receptor agonists or tirzepatide. However, given that there was more uncertainty around the cost-effectiveness of GLP-1 receptor agonists or tirzepatide use, a weak 'consider' recommendation was made. NICE guideline recommendations are for individual health and social care professionals, who should use them together with their own judgement and discussion with people using services. Therefore, healthcare professionals should use their own judgement where the recommendations do not meet the specific needs of service users.
British National Formulary	Guideline	021	008	Rec 1.8.24 Licensed product information advises that the glucose-lowering efficacy of SGLT-2 inhibitors is reduced in T2DM patients with eGFR <45 ml/min/1.73 m ² and likely absent in those with eGFR <30 ml/min/1.73 m ² . Therefore, if eGFR falls below 45 ml/min/1.73m ² , additional glucose-lowering treatment should be considered if needed. Per this recommendation, we are seeking clarification on whether dapagliflozin or empagliflozin alone in T2DM patients with eGFR >30 ml/min/1.73 m ² , when metformin is contraindicated or not tolerated, would be sufficient to achieve HbA1c targets.	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .

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British National Formulary	Guideline	021	016	Rec 1.8.26 Licensed product information advises that the glucose-lowering efficacy of SGLT-2 inhibitors is reduced in T2DM patients with eGFR <45 ml/min/1.73 m ² and likely absent in those with eGFR <30 ml/min/1.73 m ² . Therefore, if eGFR falls below 45 ml/min/1.73m ² , additional glucose-lowering treatment should be considered if needed. Per this recommendation, we are seeking clarification on whether dapagliflozin or empagliflozin alone in T2DM patients with eGFR 20 to 30 ml/min/1.73 m ² would be sufficient to achieve HbA1c targets.	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .
British Society for Heart Failure	Visual Summary			Early-onset T2DM: although defined in guideline it isn't immediately clear on visual summary. Perhaps add (<40yrs to title?)	Thank you for your comment. Additional text has been added to the visual summary to make this clearer
British Society for Heart Failure	Visual Summary			The dotted line connection ASCVD after treatment back to the ASCVD column is difficult to differentiate in colour and looks identical in black and white. Please consider making it bold or a different size / shape	Thank you for your comment. We agree that this is currently difficult to differentiate and has been changed to make it easier to see.
British Society for Heart Failure	Visual Summary			When viewed in black and white (potential if printed for quick reference) it is quite difficult to read with all the different colour shades turned grey. Has this been considered for use by those with dyslexia / divergence?	Thank you for your comment. We will check the visual summary for accessibility and make the amendments as necessary.

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British Society for Heart Failure	Visual Summary			Frailty – consideration should be given to adjustment of target in visual summary under medication review	Thank you for your comment. The committee agreed that all targets should be individualised targets. Therefore, no additional wording is needed in this case.
British Society for Heart Failure	Visual Summary			Heart failure column – It should include a bold statement that pioglitazone is contra-indicated in HF as it is listed in every other column which could invite an accidental error.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. Prescribers are expected to know about the guidance in the BNF and the particulars of medicine they are prescribing. Additionally, it is stated on the first page of the visual summary that pioglitazone is contraindicated for people with heart failure in the involving people in medicine discussions section.
British Society for Heart Failure	Guideline	004	004	Many of the welcome changes in this document involve addressing CVD risk while treating diabetes. However, diabetes is also the leading cause of CKD and we should in fact be considering CRM risk. Therefore, please include NICE CKD 2021 recommendation 1.1.14 1.1.14 Measure proteinuria with urine ACR in the following groups: adults, children and young people with diabetes (type 1 or type 2)	Thank you for your comment. This recommendation is made in the NICE CKD guideline, which is cross referenced within this guideline. Therefore, the committee were reassured that healthcare professionals could access guidance on this as required.
British Society for Heart Failure	Guideline	018	002	A recommendation should be made that good glucose control is associated with a lower risk of HF development and improvement in HF symptoms (i.e. it's a very important part of HF treatment). A review of targets, aiming for good control should be	Thank you for your comment. NICE recommendations are action-based, and generally we would not publish recommendations where the purpose is only a source of information. The rationale and impact section for people with heart failure outlines that evidence has shown that type 2

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				made for those with a diagnosis of HF, whilst avoiding hypoglycaemia. Heart Failure in Type 2 Diabetes Mellitus Circulation Research and 2023 ESC Guidelines for the management of cardiovascular disease in patients with diabetes European Heart Journal Oxford Academic	diabetes management should be holistic and take into account cardiovascular benefits instead of focusing solely on HbA1c targets. A review of target HbA1c levels (including for people with heart failure) was outside the scope of this update, however, we can pass on this information to the NICE surveillance team.
British Society for Heart Failure	Guideline	018	002	Semaglutide is included in the visual summary but has been accidentally omitted from the text. Please include in this section. We note that results from the SUMMIT trial published have not been included here – was this too late to include? – if not, the results are relevant.	Thank you for your comment. We appreciate your feedback. However, we do not believe semaglutide is included in the visual summary for this section and so it has not been omitted from the text. Therefore, we have not adjusted this section. The SUMMIT trial has not been included as it includes people with preserved ejection fraction heart failure and obesity where less than 80% have type 2 diabetes and specifically excluding people with uncontrolled diabetes. Therefore, it does not meet the criteria for inclusion by the protocol in the review.
British Society for Heart Failure	Guideline	019	009	Why are there only recommendations for semaglutide? There is a lot of new evidence expected this will make the guideline out of date. Is it more pragmatic to state 'a GLP-1 with proven CV benefit'.	Thank you for your comment. Of the GLP-1 receptor agonists and tirzepatide that we had evidence for, only subcutaneous semaglutide showed clinically important evidence of cardiovascular and renal protection and glycaemic benefits alongside a potentially beneficial weight reduction side effect while also being cost effective for people with atherosclerotic cardiovascular disease. Therefore, we have only recommended subcutaneous semaglutide for people with atherosclerotic cardiovascular disease at this time. Any relevant studies published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline

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British Society for Heart Failure	Guideline	021	006	Please include NICE CKD 2021 recommendation 1.1.14 and 1.1.21 1.1.14 Measure proteinuria with urine ACR in the following groups: adults, children and young people with diabetes (type 1 or type 2) 1.1.21 Offer testing for CKD using eGFR creatinine and ACR to adults with any of the following risk factors: Diabetes	Thank you for your comment. The scope of this update was limited to medicines for type 2 diabetes, and therefore recommendations around monitoring of CKD are out of scope. However, the recommendations on initial medicines in people with type 2 diabetes and chronic kidney disease reference NICE's guideline on chronic kidney disease [NG203], where these recommendations are covered.
British Society for Heart Failure	Guideline	021	006	The FLOW trial showed that in patients with T2DM and albuminuric CKD, the risk of CKD progression/ESRF and cardiovascular death were reduced with semaglutide. Semaglutide is included in the CVD and HF sections and should also be included in the CKD section.	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The differences from the KDIGO 2024 guideline are likely as health economics is not considered alongside the clinical evidence when making recommendations. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).

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British Society for Heart Failure	Guideline	022	005	Patients with T2DM plus CKD or T2DM plus ASCVD are also at increased risk for development of HF and a caution to consider HF risk before starting pioglitazone should be added to each of these sections.	Thank you for your comment. Several rationale and impact sections of the guideline include a statement to say that pioglitazone may worsen cardiovascular outcomes and that it should be avoided for people with heart failure. This statement is in sections for people with type 2 diabetes and no significant comorbidities, atherosclerotic cardiovascular disease, obesity, and early onset type 2 diabetes. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
British Society for Heart Failure	Guideline	022	006	For patients with DKD and proteinuria, medications to slow disease progression should be mentioned including RASi, sglT2- and Finerenone.	Thank you for your comment. Medicines to treat chronic kidney disease are out of scope for this guideline. The guideline includes a recommendation referring users to NICE's guidance on chronic kidney disease for managing other aspects of kidney disease in adults with type 2 diabetes.
British Society for Heart Failure	Guideline	022	010	The first line should be about reviewing the patient's target HbA1c to set the tone for the following medication review.	Thank you for your comment. This section is about initial medicine treatment for people with frailty. The earlier section about involving people in medicine discussions discusses HbA1c. This is then later raised in the reviewing other

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					medicines section. Based on this, we believe that the relevant sections of the guideline have statements about reviewing glycaemic targets. NICE guidelines are for healthcare professionals who should be appropriately trained and experienced to carry out the recommendations. Therefore, it would be expected that the healthcare professional would review the person's target HbA1c with the individual as part of a medicines review according to NICE's guideline on shared decision making [NG197] .
British Society for Heart Failure	Guideline	022	010	SGLT-2 inhibitors are well tolerated in heart failure and CKD patients, many of whom are frail. Meta-analyses show SGLT2 inhibitors significantly reduce all-cause mortality, cardiac death, and heart failure hospitalisations in older and frail adults. Aldafas R. Age Ageing. 2024 Jan 2;53(1):afad254. doi: 10.1093/ageing/afad254.	Thank you for your comment. In the rationale and impact section for people with type 2 diabetes and frailty the committee acknowledged that SGLT-2 inhibitors may not be appropriate for some people with frailty and type 2 diabetes, and because of a lack of evidence, they were not able to recommend a particular method of assessment or cutoff for prescribing SGLT-2 inhibitors. The rational and impact section describes how the decision to prescribe SGLT-2 inhibitors should be based on clinical judgement, taking into account the needs of the person. The committee have added specific examples of the adverse events that they are concerned about in people with frailty to the recommendation. The meta-analysis by Aldafas et al (2024) includes a mix of randomised and non-randomised studies. Of the RCTs with

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					relevant interventions and comparators, none of the studies were eligible for inclusion for the following reasons: Lee 2021: >20% of the population had prediabetes Petrie 2020: population included people with and without diabetes Singh 2020 and Tanaka 2020: mixed population of treatment naïve and people receiving concomitant antihyperglycemic medication.
British Society for Heart Failure	Guideline	022	010	'For adults with type 2 diabetes who have a level of frailty that places them at risk of adverse events from SGLT-2 inhibitors'. Please specify and define the frailty level using validated clinical tools—such as the Clinical Frailty Scale (CFS), the electronic Frailty Index (eFI), or similar standardized assessments—as well as document relevant adverse events. Without clear criteria, there is a risk that individual judgements or subjective labelling could prevent many eligible patients from accessing potentially life-saving treatment.	Thank you for your comment. The committee have added specific examples of the adverse events that they are concerned about. They believe that this statement is more specific than providing frailty scale grades as these are often automatically coded and can lead to incorrect assignment of people into groupings, leading to people not receiving treatments that are appropriate for them and creating health inequalities. Therefore, they believe that this is the more pragmatic method of deciding whether treatment is appropriate for someone or not.
CaReMe UK	Visual summary			'Stop GLP-1 receptor agonists if: • they do not help the person reach their glycaemic or weight targets, and • the person does not have cardiovascular disease or early onset type 2 diabetes'. We recommend including chronic kidney disease as a reason for not discontinuing GLP-1 receptor agonists.	Thank you for your comment. GLP-1 receptor agonists have not been recommended for use in people with CKD in this guideline.

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CaReMe UK	Visual summary			Chronic kidney disease section. We recommend including subcutaneous semaglutide in this section – to mirror the recommendations for type 2 diabetes and atherosclerotic cardiovascular disease. The current recommendation fails to consider the clinical benefits of semaglutide in people with CKD demonstrated in the Flow Study DOI: 10.1056/NEJMoa2403347. Semaglutide was demonstrated to reduce the risk of adverse kidney outcomes and cardiovascular death. We consider that the draft guideline fails to recognise the importance of risk reduction in people with chronic kidney disease and fails to prioritise appropriate drug selection in people with type 2 diabetes and CKD to same extent as people with type 2 diabetes and atherosclerotic cardiovascular disease, obesity or heart failure.	Thank you for your comment. The FLOW trial was included in the guideline. While semaglutide was found to be clinically effective in people with chronic kidney disease, when the health economic analysis was conducted, semaglutide was not cost-effective in this population. Therefore, the committee agreed that semaglutide should not be recommended for people with chronic kidney disease at this time.
CaReMe UK	Guideline	017	013	'In this guideline, SGLT-2 inhibitors and GLP-1 receptor agonists are recommended as much for their cardiovascular benefits as for their glycaemic benefits (unless otherwise specified)'. Suggest referring to both cardiovascular and renal benefits.	Thank you for your comment. We have amended this statement to include renal benefits.
CaReMe UK	Guideline	019	005	1.8.15 'For adults with type 2 diabetes and atherosclerotic cardiovascular disease, offer: • metformin, and • an SGLT-2 inhibitor, and • subcutaneous semaglutide'. [2025]. We welcome the update to now include these medications, which	Thank you for your comment and support for the guidance and evidence base.

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				are consistent with the evidence base and align with international clinical guidelines.	
CaReMe UK	Guideline	020	002	'People with early onset type 2 diabetes'. Suggesting including the definition of early onset diabetes here, or changing the heading to 'People with onset of diabetes before the age of 40' to avoid readers having to refer to the definitions section.	Thank you for your comment. Early onset diabetes is one of the "Terms used in the guideline". This terminology is hyperlinked and people will be able to find this term in the finalised version of the guideline.
CaReMe UK	Guideline	020	012	'People living with obesity'. Suggest including a definition of obesity, to avoid confusion, including different thresholds for people of relevant ethnicities.	Thank you for your comment. The sections on initial medicines and treatment options if further medicines are needed for people living with obesity now include cross-references to recommendations on classifying overweight and obesity in NICE's guideline on overweight and obesity management.
CaReMe UK	Guideline	021	006	'People with chronic kidney disease'. We recommend including subcutaneous semaglutide in this section – to mirror the recommendations for type 2 diabetes and atherosclerotic cardiovascular disease. The current recommendation fails to consider the clinical benefits of semaglutide in people with CKD demonstrated in the Flow Study DOI: 10.1056/NEJMoa2403347. Semaglutide was demonstrated to reduce the risk of adverse kidney outcomes and cardiovascular death. We consider that the draft guideline fails to recognise the importance of risk reduction in people with chronic kidney disease and fails to prioritise appropriate drug selection in people with type 2 diabetes and CKD to same extent as people with type 2 diabetes and atherosclerotic cardiovascular disease, obesity	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population in this study was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).

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				or heart failure. We note that the health economic modelling in relation to chronic kidney disease, considers only end stage kidney disease outcomes and does not acknowledge the clinical and quality-of-life benefits of delaying kidney disease progression in individuals with type 2 diabetes and CKD.	
CaReMe UK	Guideline	021	010	We recommend adding canagliflozin to the SGLT2 inhibitors in addition to dapagliflozin and empagliflozin. In the CAVVAS study, canagliflozin significantly reduced 3-point MACE. In addition, CREDENCE supports the use of canagliflozin in people with type 2 diabetes, CKD with proteinuria.	Thank you for your comment. The CANVAS and CREDENCE trials were included in this review. The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .
CaReMe UK	Guideline	022	001	'1.8.27 For adults with type 2 diabetes and an eGFR below 1 20 ml/min/1.73 m ² , consider a DPP-4 inhibitor. [2025]'. We fail to understand why a DPP-4 inhibitor is recommended in this section, in the absence of any evidence of clinical benefit in reducing adverse kidney outcomes or preventing cardiovascular events. We urge the committee to include semaglutide as the preferred drug in the setting of type 2 diabetes in people with chronic kidney disease, reflecting the clinical benefits demonstrated in the Flow Study DOI: 10.1056/NEJMoa2403347.	Thank you for your comment. The rationale for DPP-4 inhibitors can be read in the rationale and impact section. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets

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					(as per guidance about choosing which comorbidity to manage).
CaReMe UK	Guideline	025	016-017	'1.8.43 Stop GLP-1 receptor agonists if: • they do not help the person reach their glycaemic or weight 14 targets, and • the person does not have atherosclerotic cardiovascular disease 16 or early onset type 2 diabetes. [2025]' We recommend including chronic kidney disease as a reason for not discontinuing GLP-1 receptor agonists.	Thank you for your comment. We have not recommended GLP-1 receptor agonists for people with type 2 diabetes and chronic kidney disease. Therefore, the wording for this section does not need to be amended for this.
Centre for Perioperative Care	Evidence reviews	General		The evidence reviews cover large numbers of drug trials and do not include any lifestyle and dietary modifications.	Thank you for your comment. Lifestyle and dietary modifications were outside of the scope of this guideline update and so are not included in the evidence reviews. However, we have now made the information on lifestyle and dietary modifications more prominent within the guideline in relation to medicines. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
Centre for Perioperative Care	Guideline	General		This proposed guideline fails future patients by not including evidence about low carbohydrate diets potentially putting type 2 diabetes into remission. The evidence reviews are only about pharmaceuticals.	Thank you for your comment. This guideline update is about medicines. Low carbohydrate diets are out of scope of the guideline update. This has been updated recently in the overweight and obesity management guideline and cross references have been made to this guideline. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy

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					living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
Centre for Perioperative Care	Guideline	007	023	"1.3.7 Individualise recommendations for carbohydrate and alcohol intake, and meal patterns." Please add "There is some evidence that reducing carbohydrate intake can put type 2 diabetes into remission. Avoiding carbohydrates reduces spikes in Insulin and hunger and further limits fat deposition from the storage of excess carbohydrates."	Thank you for your comment. This is out of scope for the guideline update.
Centre for Perioperative Care	Guideline	021	010	I wonder why the CANVAS and CREDENCE data has been ignored and canagliflozin not recommended?	Thank you for your comment. The CANVAS and CREDENCE trials were included in this review. The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .
Centre for Perioperative Care	Guideline	024	007-012	RE: "1.8.37 Advise adults with type 2 diabetes who are taking an SGLT-inhibitor that a very low carbohydrate or ketogenic diet would increase their risk of DKA and so: • they should speak with their healthcare professional before starting such a diet, and • their SGLT-2 inhibitor treatment may need to be suspended for the duration of the diet. [2022]"	Thank you for your comment. The effectiveness of low-carbohydrate diets was investigated as part of the overweight and obesity management guideline update. The evidence review reported evidence on low-carbohydrate diets demonstrated that for almost all outcomes, the diet did not result in improvements in weight, BMI, waist circumference or HbA1c.

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				Please can you adapt this to be more positive about the low carbohydrate diets? These are a valuable option. It should be the other way round – that if they want to try the diet they should be supported to stop the medication. Please add: “Advise adults with type 2 diabetes who wish to try or continue with a low carbohydrate diet, very low carbohydrate or ketogenic diet that these diets can put their type 2 diabetes into remission, so further medication may not be required – and reduction in drug therapy may need support from a clinician.”	The committee agreed to keep the current advice in the recommendation.
Centre for Perioperative Care	Guideline	027	002	After “1.8.47 Consider adding subcutaneous semaglutide for adults with type 2 diabetes and heart failure who need further medicines to reach their weight management targets, if • they are living with obesity” Please add: “This should be accompanied by: advice to maintain mineral and vitamin intake to reduce the risk of malnutrition, exercise to reduce the loss of muscle mass, and support especially to build good nutritional habits when the medication is reduced.” [See:	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is

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				https://www.bmj.com/content/bmj/390/bmj.r1512.full.pdf]	appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management. Recommendations around diet are in the Dietary advice section of NICE's guidance on type 2 diabetes in adults: management [NG28] . This area was out of scope for this update. An additional recommendation has been added to the Involving people in medicine discussions section to ensure people discuss healthy living before all medicine discussions.
Centre for Perioperative Care	Guideline	027	002	With the tirzepatide SUMMIT trial, why not include tirzepatide in those with HFpEF?	Thank you for your comment. The SUMMIT trial includes people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update.
Centre for Perioperative Care	Guideline	028	001	With the publication of the SURPASS CVOT data, tirzepatide needs to be added to the ASCVD pathway	Thank you for your comment. While we have seen the initial findings from the SURPASS CVOT trial, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection while GLP-1 receptor agonists included in the review have shown this and subcutaneous semaglutide has also shown cost-effectiveness, therefore has been recommended. Any relevant studies such as the SURPASS-CVOT trial published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline

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Centre for Perioperative Care	Guideline	028	002, 013, 016	1.8.49, 18.51 and 1.8.52: After each recommendation to add a GLP-1 receptor agonist, please add: Please add: "This should be accompanied by: advice to maintain mineral and vitamin intake to reduce the risk of malnutrition, exercise to reduce the loss of muscle mass, and support especially to build good nutritional habits when the medication is reduced." [See: https://www.bmj.com/content/bmj/390/bmj.r1512.full.pdf]	Thank you for your comment. Recommendations around diet are in the Dietary advice section of NICE's guidance on type 2 diabetes in adults: management [NG28]. This area was out of scope for this update. An additional recommendation has been added to the Involving people in medicine discussions section to ensure people discuss healthy living before all medicine discussions.
Centre for Perioperative Care	Guideline	028	004	With the publication of the SURPASS CVOT data, tirzepatide needs to be added to the ASCVD pathway	Thank you for your comment. . While we have seen the initial findings from the SURPASS CVOT trial, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection while GLP-1 receptor agonists included in the review have shown this and subcutaneous semaglutide has shown this and cost-effectiveness, therefore being recommended. Any relevant studies such as the SURPASS-CVOT trial published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline

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Centre for Perioperative Care	Guideline	029	010	In the obesity pathway, why only use a GLP-1? With the data from SURPASS 2, why not also consider tirzepatide given its superior efficacy in glycaemic control and weight reduction?	Thank you for your comment. SURPASS 2 was included. The wording has now been changed to say "GLP-1 receptor agonist or tirzepatide" to show the role of tirzepatide in this population.
Centre for Perioperative Care	Guideline	031	001	With the data from the FLOW trial, showing renal benefit of semaglutide, that needs to be added to the CKD pathway.(and page 82 lines 28)	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Centre for Perioperative Care	Guideline	031	003	Should thus not say eGFR appropriate dose?	Thank you for your comment. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC

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					for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Centre for Perioperative Care	Guideline	032	020	If someone has a high HbA1c and I add insulin, I will often not stop the oral agents – e.g. pio, or the SU, only if I feel there is an added risk of hypoglycaemia.	Thank you for your comment. The committee highlight the risk that sulfonylureas and insulin-based treatments have in causing hypoglycaemia and falls. For this population, the committee consider it important that the smallest effective number of treatments are being used at the lowest effective dose to reduce the impact on their quality of life. However. the therapy for each person should be considered on a case-by-case basis.
Centre for Perioperative Care	Guideline	034	017	No suggestion / recommendation for Fixed Dose combination of GLP- 1 and long acting insulin?	Thank you for your comment. Further information around fixed dose combinations of insulin degludec and liraglutide is provided in the link to the MHRA's guidance on minimising the risk of medication error with high strength, fixed combination and biosimilar insulin products.
Centre for Perioperative Care	Guideline	036	005	The gastroparesis section needs to have comments about perioperative diabetes care – in particular that where possible, shared decision making about stopping the drug should be made between the anaesthetist and patient, and that in general, GLP-1 agents should not be stopped, and SGLT2 inhibitors should be stopped the day before a procedure – in line with CPOC guidance (Perioperative Care of People with Diabetes Undergoing Surgery Centre for Perioperative Care). That if gastroparesis is suspected that mitigation strategies should be used – e.g. off label	Thank you for your comment. The gastroparesis section of the guideline is out of scope for this update, and so we are unable to make changes to these recommendations.

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				preoperative low dose (0.5mg/kg) IV erythromycin, point of care gastric ultrasound and anaesthetic techniques to reduce the risk of pulmonary aspiration.	
Centre for Perioperative Care	Guideline	052	002	Now that dapagliflozin is generic, with comparable CVOT / HF / CKD data to empa, will the 'lowest acquisition cost' clause be reinserted?	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors

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					and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
Centre for Perioperative Care	Guideline	057	005	Previous NICE guidance has often said 'agent with the cheapest acquisition cost' – here for GLP-1's, with CVOT data, it is likely to be generic liraglutide. Are NICE saying do not use this, but semaglutide or tirzepatide? (mentioned on page 80 line 22)	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors

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					and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
Centre for Perioperative Care	Guideline	083	012	With the epidemiologically increased risk of distal forearm fractures in pio users (e.g. Pioglitazone and Risk for Bone Fracture: Safety Data From a Randomized Clinical Trial - PMC), should it be recommended in those with frailty?	Thank you for your comment. Thank you for the link to the article also. Pioglitazone has been recommended as an option in situations where initial treatments have not been sufficient to achieve glycaemic control or where they are contraindicated or not tolerated. As information on fracture risk is known and covered in the drug's SmPC, the committee decided that this did not need to be stated in a recommendation. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Centre for Perioperative Care	Guideline	084	021	BNF prices states that branded lantus is 30% cheaper than abasaglar, so this statement is currently incorrect?	Thank you for your comment. This section was out of scope for this guideline update as it is a historical reference to the previous recommendations. However, the statement is still appropriate as it states that if a biosimilar is available, then (the

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					medicine) with the lowest cost should be used. If that is not the biosimilar, then the branded formulation can be used. Therefore, this does not need to be edited to maintain the meaning of the recommendation.
Diabetes UK	Guideline	General		We work closely with researchers at Exeter University, and they have run an analysis to create the 7 proposed subgroups in UK data (CPRD) of ~500,000 people with type 2 diabetes to assess how the proposed guidance could look in practice. This analysis suggests that the majority of people with type 2 diabetes who have another comorbidity do not fit into a single treatment subgroup (e.g. only 16.4% of people with type 2 diabetes and frailty have frailty alone) making practical implementation of the guidance difficult for many people.	Thank you for your comment and for sharing these interesting figures. We agree and are supportive of this work. We have made adjustments to the guideline and an additional recommendation to help provide guidance on how to implement the principles when people have multiple comorbidities as we acknowledge this is the reality for a lot of people. The committee agreed this was important from the start of writing the guideline and wanted to ensure that we had a way to address this. However, the evidence does not align with this where it is often presented in specific groups. Given this, and in an attempt to align with the evidence, they agreed to recommend by population group. However, it is reinforced throughout that people should consider the whole person and the treatments that are most important for their care as a whole.
Diabetes UK	Guideline	General		This analysis also suggests that the recommendation for injectable semaglutide as part of triple therapy for people with ASCVD will disproportionately affect different ethnic groups. Strikingly, 24% of people with type 2 diabetes of white ethnicity will meet this criteria, much higher than for other ethnicities (South Asian 17.6%, Black 11.5%, Mixed 15.2%, Other 14.2%). The researchers suggest that using a sub categorisation	Thank you for your comment and for providing this data. We agree that personalised decisions are the right way to approach prescribing and have made recommendations to support this. We agree that further work would be needed to account for wider factors that are not already considered in this work, such as ethnicity. The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it

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				approach to determine prescribing could be a problem and that a better approach would be to truly focus on each individual. We can supply further information and contact details to obtain the data to support these comments if required. We appreciate that currently the sub categorisation approach might be the most practical, but in the near future we would hope that it would be possible for clinicians to make more personalised prescribing decisions supported by precision tools that calculate individualised risk. See our further research recommendations above.	was most important to make recommendation based on the evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. A recommendation was added with simplified principles for supporting personalised care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to advise people to account for: a) medicines required for cardiovascular and renal protection, b) medicines that are contraindicated, c) medicines optimisation especially for people with frailty. Further information can be found in the committee discussion document. NICE is considering development of a clinician discussion aid to support this.
Diabetes UK	Guideline	General		Overall we are very pleased to see this updated guideline and urge that it is communicated widely and implemented urgently.	Thank you for your comment. We appreciate your feedback and support.
Diabetes UK	Guideline	050-051	029-030 001-007	We suggest that this guidance for whom modified release might be a preferable option should go in the main body of the guideline.	Thank you for your comment. The guideline has now been updated to recommend modified release metformin for most

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					people as initial treatment. Therefore, this section has now been removed from the rationale.
Diabetes UK	Guideline	005	010-013	We were pleased to see a cross reference to the NICE guideline on eating disorders and specific reference made to this	Thank you for your comment.
Diabetes UK	Guideline	007	011-014	We are pleased to see cross reference made to the guideline on overweight and obesity management and to the NHS type 2 diabetes Pathway to remission programme. Is it possible to include clearer signposting on eligibility and referral thresholds for total diet replacement/very-low-energy diets and metabolic surgery, and how these interface with new pharmacotherapy in this section? The concern is that with the current layout there is a risk of care becoming siloed.	Thank you for your comment. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A cross-reference link has been added to the NHS Pathways to Remission programme which can be used to access eligibility and referral thresholds. A cross reference has also been added to recommendations on low-energy and very-low-energy diets to achieve type 2 diabetes remission which was considered as part of the update of the overweight and obesity management guideline (NG 246).
Diabetes UK	Guideline	007	015-017	Please consider highlighting the importance of equitable access to community dietitians to reduce the risk of widening inequalities.	Thank you for your comment. The dietary advice section of the type 2 diabetes guideline (NG28) was out of scope for this medicines update.

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Diabetes UK	Guideline	010	023	We were pleased to see the directive to intensify medicines.	Thank you for your comment.
Diabetes UK	Guideline	010 and general	General	We were pleased to see the change in language from use of "lifestyle" but feel advice could be more specific in some cases and talk about "diet and physical activity levels" (though we appreciate that smoking and drinking alcohol are also unhealthy behaviours that might need to be addressed).	Thank you for your comment. This section was amended for updating language only and was out of scope for this guideline update. The change from "lifestyle" to healthy living" reflects an update in the language from the previous iteration of the recommendation. This includes a link to the NHS Better Health website which provides more information about what is entailed in this. Whilst healthy living is mentioned in the guideline, this update is focussed on medicines. For information on weight management we recommend that guidance is sought from NICE's guideline on overweight and obesity management. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
Diabetes UK	Guideline	015	002	The visual summary is excellent but we would like to see it included in the guideline itself as well as a separate document.	Thank you for your comment. The link for the visual summary will be added to the start of the guideline and additionally within the medicines section so that users can easily navigate to it.
Diabetes UK	Guideline	015	010	Excellent that the effectiveness of the medicines in terms cardiovascular and renal protection are to be taken into account.	Thank you for your comment.

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Diabetes UK	Guideline	015	014-016	It's good to see shared decision making brought in, but we are not entirely sure it's necessary here when much of the advice is the same (especially when considering the exception to this is the heart failure category where pioglitazone is not a choice – and shouldn't be as it's contraindicated. But as currently written the concern might be for someone to say they are prioritizing obesity over heart failure for example leading them to accidentally receiving pioglitazone).	Thank you for your comment and for your assessment of the clinical realities of type 2 diabetes. The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it was most important to make recommendation based on the evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. The committee agree with your assessment of multiple comorbidities. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to support this. Further information can be found in the committee discussion document. The specific example of heart failure and pioglitazone has now been referenced in the recommendation.
Diabetes UK	Guideline	016	007-016	We very much welcome the inclusion of need to give clear and specific sick day rules.	Thank you for your comment.
Diabetes UK	Guideline	020	003-011 and general	There seems to be limited modelling for GLP1s as monotherapy, especially for younger people with	Thank you for your comment. Please read the corresponding rationale and impact section and the committee discussion

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				obesity. Greater flexibility around initiating GLP-1s would likely be welcomed in primary care. Some further clarity on the evidence supporting metformin + GLP-1 combinations would also be helpful.	document for this area for further information. No evidence was identified for any antidiabetic therapy for people with early-onset type 2 diabetes. For people with type 2 diabetes and obesity, the recommendations were made because of cardiovascular and renal protection benefits plus glycaemic reduction properties. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this.
Diabetes UK	Guideline	023	015-016	Consider including the necessity to have tailored diet and exercise advice for people on these medications to maximise their effectiveness and prevent the loss of muscle mass.	Thank you for your comment. Diet and exercise advice is outside of the scope for this guideline update. A new recommendation has been added to the section discussing involving people in medicine discussions which reinforces this advice for all medicine discussions.
Diabetes UK	Guideline	025	007-008	The recommendation to consider keeping people on medications once their weight or glycaemic target is reached is good – might the example of continuing GLP1s following weight loss be used here to explicitly signal that this could be beneficial?	Thank you for your comment. We believe that the recommendation is already clear in this statement, therefore we have not added any clarifiers to the recommendation.
Diabetes UK	Guideline	025	013-017	Clearer guidance on when to continue/stop GLP-1s would be welcomed in primary care especially in the context of cardiometabolic benefit irrespective of weight response - this would help to reduce unwarranted variation	Thank you for your comment. The guidance is clear that GLP-1 receptor agonists or tirzepatide should not be stopped if the person has atherosclerotic cardiovascular disease or early onset type 2 diabetes where the aim is definitively to provide cardiovascular and renal protection. For other reasons where

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					the reason is more mixed or the evidence is less clear, this should be based on whether it helps people to reach their individualised glycaemic targets.
Diabetes UK	Guideline	028	013-015	We welcome both the use of SGLt2's and GLP1s earlier in the pathway and tailored management to individual cohorts.	Thank you for your comment.
Diabetes UK	Guideline	029	011-016	The guidance appears inconsistent with NICE's tirzepatide recommendations (TA924), which do not require a three-month metformin trial before starting a GLP-1. This may cause confusion for GPs. It would be useful if the guideline addressed this explicitly, especially given the significant psychological and medical comorbidities often present in people with T2DM living with severe obesity.	Thank you for your comment. The committee recommended initial treatment with an SGLT-2 inhibitor in addition to metformin because of the cardiovascular and renal protective benefits of SGLT-2 inhibitors. The committee discussion highlights the committee's experience that it is possible for people to have clinically important reductions in weight as a side effect with an SGLT-2 inhibitor and metformin. Given all of this, GLP-1 receptor agonists or tirzepatide should only be added at least 3 months after initial treatment with metformin and an SGLT-2 inhibitor, which is covered in recommendations on treatment options if further medicines are needed. If the person's glycaemic targets have not been met, then there is a consider recommendation to add a GLP-1 receptor agonist or tirzepatide. If the person's weight targets have not been met, then this is outside the scope of this guideline, and healthcare professionals should refer to NICE's guideline on Overweight and obesity management [NG246] .
Diabetes UK	Guideline	030	015	The word "controlled" could be changed here to "managed" or an alternative	Thank you for your comment. This recommendation has now been removed as the use of tirzepatide has now been added

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					into the guideline, which means this wording is no longer present.
Diabetes UK	Guideline	031	001-009	We would query the lack of inclusion of GLP1-RA / semaglutide in the CKD subgroup – given there is good evidence for kidney benefit - notably this meta-analysis which included 11 trials, with various GLP1-RAs: https://www.sciencedirect.com/science/article/pii/S213858724002717?via%3Dihub and the FLOW trial, the only kidney-outcome trial (with sc semaglutide) FLOW trial, Perkovic et al N Engl J Med 2024;391:109-121 https://www.nejm.org/doi/full/10.1056/NEJMoa2403347	Thank you for your comment. The meta-analysis referenced would not be included in our analysis because it includes the drugs efpeglenatide and albiglutide, both of which are listed in protocols as excluded medicines. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Diabetes UK	Guideline	033	007-011	For clarity it might better to say “short or rapid acting” here as we think this is what is intended?	Thank you for your comment. This has now been added.
Diabetes UK	Guideline	033	020-021	This advice contradicts advice in earlier sections where it says “add” – we note that it then hyperlinks to this section but many people during clinical practice do not have time to follow all links. We suggest you consider changing the info in above sections to say - OR change to insulin (with metformin if tolerated)	Thank you for your comment. The recommendation states to stop any other medicines that are being used solely to manage hyperglycaemia. As SGLT-2 inhibitors and some recommendations for GLP-1 receptor agonists are being given for reasons that go beyond managing hyperglycaemia (cardiovascular and renal protection) the recommendation does not say to stop these treatments. Treatments to be

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					stopped under this recommendation would include DPP-4 inhibitors, sulfonylureas and pioglitazone. So instead, this recommendation is likely appropriate, as when someone starts insulin, they are linked to this section and then will stop any treatment that is only for glycaemic benefits. A visual summary has been developed to accompany the guideline, and this should help busy healthcare professionals during clinical practice. NICE is continuing to develop how it delivers guidance to improve how usable the content it develops is.
Diabetes UK	Guideline	034	013-017	We think this is not entirely clear – is the suggestion to add a short acting insulin 3 times a day with a biphasic insulin? This would be unusual - but less so if only adding at lunch (where there is no meal coverage left working in the biphasic). Needs to be clear.	Thank you for your comment. This has been discussed with the committee, and the recommendation has been updated to changing to a different biphasic insulin preparation or to change to a basal-bolus regimen intended for administration once or twice a day.
Diabetes UK	Guideline	041	009-011	We welcome this research recommendation on treatment strategies for people with type 2 and frailty	Thank you for your comment
Diabetes UK	Guideline	043	General (research recommendations)	We propose two further recommendations for research: “Optimisation of glucose-lowering treatment: What is the clinical and cost-effectiveness of more personalised treatment strategies to optimise glycaemic control in people with type 2 diabetes, and can this inform healthcare professionals' decisions about prescribing? (See	Thank you for your comment. Personalised treatment strategies were not covered by this guideline therefore we cannot make a research recommendation in this area (as we cannot say whether research already exists in this area).

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				our comments numbered 27 and 28 for the rationale).	
Diabetes UK	Guideline	043	General (research recommendations)	"Treatment strategies based on individual-level risk: What is the clinical and cost-effectiveness of utilising individual-level risk prediction models for atherosclerotic cardiovascular disease, heart failure, renal disease and glycaemic/weight control, to select and personalise treatment in people with type 2 diabetes?" (See our comments numbered 27 and 28 for the rationale).	Thank you for your comment. Individual risk prediction models were not covered by this guideline and therefore we cannot make a research recommendation based on this (as we cannot confirm whether there is already evidence in this area or not).
Diabetes UK	Guideline	050	016-025	We are aware that some people really struggle with standard release metformin and that this first bad experience with a diabetes treatment could lead them to disengage from treatment. We recommend that people are proactively reviewed following initiation on standard release metformin in order to identify any side effects and that they are moved to modified release speedily if they are having difficulty.	Thank you for your comment. The guideline has now been updated to recommend modified release metformin for most people as initial treatment. The guideline includes a separate recommendation discussing reviewing metformin for people who are taking standard-release metformin and offering modified-release metformin if standard-release metformin is not tolerated. These recommendations are in the section for reviewing medicines.
Diabetes UK	Guideline	068	005	This recommendation to introduce the drugs sequentially should be in the main recommendations higher up in the guideline	The recommendation is in the 'How to introduce medicines' section. The reason that the 'Initial medicines' section precedes the 'How to introduce medicines' section is because the user requires knowledge about which medicines need to be introduced in order to understand how treatment should be introduced.
Diabetes UK	Guideline	086	012-015	We are concerned that there may not be sufficient NHS dentists to cope with this, and also whether	Thank you for your comment. This section is out of scope for this guideline update and reflects the rationale for a previous

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				there are currently specific pathways for clinicians to follow? Implementing this recommendation will require further work and guidance to ICBs to ensure people with diabetes are getting the access to NHS dentists that is needed. This is a health inequalities issue given the paucity of NHS dentists in many areas across the country and the high prevalence of type 2 diabetes in areas of high deprivation.	guideline update. This refers to a set of recommendations from 2022 that should already be in place. This will be passed to surveillance for consideration for future work.
DIME square Ltd	Visual summary	CKD column		No mention of urine ACR result (you are only stating eGFR). A confirmed urine ACR of 3 or more, is a key part of the CKD diagnosis in the CKD NICE guidelines and has been overlooked. Using one of the three SGLT-2 inhibitors with proven renal benefit for people with type 2 diabetes is also important and equitable. Unsure why you have excluded Canagliflozin in the management of type 2 diabetes in adults guidelines (already highlighted in comments 3 and 5 (including references))	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact sections of the guideline. A cross reference is made to NICE's guideline on chronic kidney disease which discusses this. No other references to ACR have been made because no recommendations in the guideline reference this. Additionally, there is now a recommendation for offering any SGLT-2 inhibitor for those with an eGFR above 30 ml/min/1.73 ² (please see responses to earlier comments).
DIME square Ltd	Guideline	018	004	1.8.9 Is it appropriate to add a lower BMI threshold when adding a SGLT-2 inhibitor, to ensure potential insulinopenic patients with lower BMIs are not routinely prescribed SGLT-2 inhibitors?	Thank you for your comment. On considering weight loss due to SGLT-2 inhibitors, the committee agreed that this was likely associated with fluid loss due to excretion by urine as a part of the mechanism of action of SGLT-2 inhibitors. Therefore,

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					unlike with GLP-1 receptor agonists where an additional recommendation has been made in this scenario, a new recommendation for SGLT-2 inhibitors was not made in this case. Healthcare professionals should always consider the benefits and risks of treatments for each person on a case-by-case basis and whether a treatment is appropriate for them.
DIME square Ltd	Guideline	019	023	1.8.15 Recommending Semaglutide only. Is there a reason Dulaglutide has been omitted? CVOT study results similar to Semaglutide. Also SURPASS CVOT results being presented at the EASD conference Sept 2025 and should be included if results positive. This is also stated in 1.8.49 row 4	Thank you for your comment. Not enough evidence was received for the SURPASS-CVOT trial to assess cardiovascular and renal benefits for tirzepatide in people with atherosclerotic cardiovascular disease. Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide for people with atherosclerotic cardiovascular disease at this time.
DIME square Ltd	Guideline	020	004	You have stated specific SGLT-2 inhibitors in the CKD section. In the Young-Onset Type 2 diabetes is it appropriate to state the SGLT-2 inhibitor with greatest HbA1c and weight efficacy based on evidence. Canagliflozin 100mg, increasing to 300mg if eGFR remains > 60. NICE has always recommended using the medication within the class which is the most effective for the individual and Canagliflozin meets the criteria for this group. This also fits with 1.8.39 of the guidance – line 20.	Thank you for your comment. For people who do not have chronic kidney disease (where there are reasons stated in the summary of product characteristics that mean that specific SGLT-2 inhibitors should not be used) there is no reason based on clinical effectiveness that one SGLT-2 inhibitor should be prioritised over another. They all were of relative clinical effectiveness. When examining cost effectiveness, they were all examined as a class. Therefore, they were recommended as a class.

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				1. Zaccardi F. et al. 2017 Efficacy and safety of sodium-glucose co-transporter-2 inhibitors in type 2 diabetes mellitus: systematic review and network meta-analysis, Diabetes Obesity and Metabolism, 2016 ;18(8):783-94. https://doi.org/10.1111/dom.12670 INTENSIFY study group, Effectiveness and Tolerability of the Intensification of Canagliflozin Dose from 100 mg to 300 mg Daily in Patients with Type 2 Diabetes in Real Life: The INTENSIFY Study, Journal of Clinical Medicine, 2023;12(13):4248. https://doi.org/10.3390/jcm12134248	
DIME square Ltd	Guideline	020	011	As a trainer of healthcare Professionals who always quotes NICE, can you be clear if stating GLP-1 Receptor Agonist, you are excluding the use of the dual GIP/GLP-1 Receptor Agonist, or including it. Needs to be clearer, especially with Young-Onset Type 2 group. This is repeated in 1.8.52 row 17/18	Thank you for your comment. This has been changed to “GLP-1 receptor agonist or tirzepatide” to include tirzepatide.
DIME square Ltd	Guideline	021	012	You have stated two of the SGLT-2 inhibitors for use with CKD, yet Canagliflozin also has a renal study for people with type 2 diabetes ¹ and has greater efficacy with HbA1c reduction ² You mention eGFR level in your algorithm document but do not mention urine ACR > 3 and use of SGLT-2 inhibitors. Canagliflozin has a place with young-onset type 2 diabetes and working-aged people with an eGFR > 30 and an ACR > 3, ensuring best	Thank you for your comment. Perkovic 2019 was included in the review. The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .

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				Hba1c reduction efficacy in class, which remains extremely important with younger people with type 2 diabetes. It is incorrect to discount it from the list. This is a Type 2 management document and not CKD in the general population. 1. Perkovic V et al. Canagliflozin and renal outcomes in type 2 diabetes and nephropathy, NEJM, 2019;380(24):2295-2306. DOI: 10.1056/NEJMoa1811744 Zaccardi F. et al. 2017 Efficacy and safety of sodium-glucose co-transporter-2 inhibitors in type 2 diabetes mellitus: systematic review and network meta-analysis, Diabetes Obesity and Metabolism, 2016 ;18(8):783-94. https://doi.org/10.1111/dom.12670	
DIME square Ltd	Guideline	025	005	Can you bring in – or not adhering to twice daily standard Metformin (this appears elsewhere on the algorithm and in the guidelines, but would simplify the message if added here)	Thank you for your comment. We have used the word “tolerated” here to cover situations where standard-release metformin is not tolerated due to side effects which can lead to problems with adherence, in these situations a person can be switched to modified-release metformin. In recommendation 1.8.32 we state taking into account adherence, this recommendation applies to all medicines. Please refer to the committee discussion in the evidence review document for discussion on tolerance and adherence.

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					We have subsequently updated the recommendations so everyone is recommended modified release metformin as initial treatment rather than standard release metformin.
DIME square Ltd	Guideline	029	011	1.8.54 – clarity on definition of 'obesity' would be useful for training purposes. Do you mean BMI > 30 (in line with SIGN guidelines). How would this be reduced for ethnic groups? Clarity required	Thank you for your comment. The guideline now has cross references to the definitions used in the overweight and obesity management guideline to clarify this.
DIME square Ltd	Guideline	038	019	1.8.59 Frailty. Question use of Pioglitazone with this group due to increased fracture risk. Recommend removing Pioglitazone	Thank you for your comment. Here pioglitazone is being recommended as an option in situations where adults with T2DM and frailty need further medication to reach their glycaemic targets when other options are not tolerated, contraindicated or not effective. As information on fracture risk is covered in the drug's SPC, the committee decided that not to specify this. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Dirac Foundation	General			General and F9-F13 e.g. F13. The study method involves independence assumptions. Is further	Thank you for your comment. This update included evidence from over 550 RCTs. NICE's focus is on developing more

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				information available e.g. in patient records, in a form which can serve as a retrospective cohort study by means of data mining, and verify and/or fill gaps regarding the validity of the conclusions? Clarification: I understand the preference of NICE for RCT methods; Health Technology Evaluation Manual (NICE PMG36). The meta-analysis over very different RCT studies causes potential difficulties that could be supported by further means. A "network of evidence for additive change in weight in the subpopulation" refers to a network meta-analysis that uses statistical methods to combine evidence from multiple studies to compare treatments' effects on weight, assuming these effects are additive and not complicated by cross-terms. In other words, it has independence assumptions. These assumptions do of course allow researchers to assess treatment efficacy within specific groups, such as those with both diabetes and chronic kidney disease, even when direct comparisons between all treatments are not available across every study. In the Bristol Report Network meta-analysis (NMA) models were based	relevant, timely, useable and impactful guidance. Including non-randomised studies in addition to a large number of RCTs would make us less able to develop timely guidelines. Developing NICE guidelines: the manual [PMG20] describes that where randomised evidence is insufficient for decision making, non-randomised may be used for estimating the effects of interventions. This would not apply in the case of this update as the evidence base of randomised studies was so large.

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				on TSD code TSD2-8 (Normal shared), which uses a Normal likelihood with an identity link function and thus assumes additivity of treatment effects. That is, NMA assumes consistency between direct and indirect comparisons: $\delta(A,C) = \delta(A,B) + \delta(B,C)$. In effect, this means that there are independence assumptions. For example, Example: Trial 1: Drug A vs. Placebo, Trial 1: Drug A vs. Placebo, Trial 2: Drug B vs. Placebo, Trial 3: Drug C vs. Drug B allows us to indirectly compare A vs. B, A vs. C, etc., by combining all evidence consistently. But "consistently" is misleading. It is a matter of data dimensionality and interdependence between factors. A study may likely show that elderly male patients associate with anaemia, and pregnant patients associate with anaemia, but there are no or few observations of pregnant elderly male patients with anaemia. Also, details can be lost on stratification of patient groups. I understand NICE PMG36 also allows that, while randomised controlled trials (RCTs) are the preferred evidence source for comparing treatment effects, other study designs like non-randomised studies or real-world evidence can be used, especially when direct comparative evidence is	

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				lacking. Notably, extensive numbers of deidentified patient records in structured form could be helpful. That simply means retrospective cohort studies. See following links on pilot studies and a historical study, an older FDA white paper though updated if needed, and the current FDA position. https://www.sciencedirect.com/science/article/abs/pii/S0010482524001690 https://www.sciencedirect.com/science/article/abs/pii/S0020025524009411 https://www.sciencedirect.com/science/article/abs/pii/S0010482505001046 https://www.fda.gov/science-research/data-mining/data-mining-fda-white-paper (2018 but updated when needed) https://www.fda.gov/regulatory-information/search-fda-guidance-documents/real-world-data-assessing-registries-support-regulatory-decision-making-drug-and-biological-products (2023)	
Dirac Foundation	F13	001	015	"These analyses focus on people with type 2 diabetes mellitus (T2D) and chronic kidney disease (CKD). Studies in people with CKD primarily were not included in the evidence, including where a T2D subgroup was reported." Either the meaning of "CKD primarily" is not going to be too clear to some stakeholder analysts, or the omission needs to be explained.	Thank you for your comment. We agree this was not clear and have added wording to clarify this. This statement highlights exclusion criteria in the protocol that studies with a mixed population of people with and without diabetes would be excluded. This meant that if the study primarily recruited people with CKD, so that the population included people with and without diabetes, then this study would not be eligible for inclusion.

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East Sussex Healthcare Trust	EHIA	General		Given the committee were presented with real world evidence that showed that SGLT-2 inhibitors are under-prescribed, particularly to women and older people, and to people from some ethnic backgrounds should this be woven throughout the guideline? There is a section on early onset type 2 diabetes, is there the opportunity to highlight health inequalities? Additionally, given there are specific recommendations for CGM monitoring (1.7.26) "Commissioners, providers and healthcare professionals should address inequalities in CGM access and uptake by monitoring who is using CGM, identifying groups who are eligible but who have a lower uptake, making plans to engage with these groups to encourage them to consider CGM", is there the opportunity to consider similar recommendations for SGLT2i monitoring given the EHIA and SGLT2i uptake report?	Thank you for your comment. The committee agreed with your suggestion. We have added a recommendation to capture this in the section 'Addressing inequalities in use of SGLT-2 inhibitors'.
East Sussex Healthcare Trust	Health economic analysis			Tirzepatide is not considered in the economic analysis. Exenatide has been discontinued in the UK but has been included in the economic analysis.	Thank you for your comment. The committee reviewed the evidence for the cost-effectiveness of tirzepatide for managing type 2 diabetes, as outlined in NICE TA924. The committee amended their recommendations to include tirzepatide

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					wherever the class of GLP-1 receptor agonists are recommended. Exenatide has been removed from the analysis.
East Sussex Healthcare Trust	Resource impact template	General		The resource impact tool gives modelling for GLP-1 RAs for ASCVD and early onset. Is there modelling for impact in obesity?	Thank you for your comment. We have focused our workings on the initial treatments where significant resource impact is expected. The recommendation for GLP-1 receptor agonists for those with obesity are consider recommendations when further treatment may be needed.
East Sussex Healthcare Trust	Visual summary	General		States "at each point reinforce advice about diet and behaviour change"- opportunity to include healthy living	Thank you for your comment. This has now been changed to diet and healthy living.
East Sussex Healthcare Trust	Visual summary	General		The algorithm implies offering agents together, however the guideline states to confirm tolerability before introducing the next agent, this may lead to confusion if not read in conjunction	Thank you for your comment. The visual summary has been updated to make it clear to initiate drugs sequentially.
East Sussex Healthcare Trust	Visual summary	General		There is a concern that the first column 'no relevant comorbidities' downplays people who are at high risk of CVD and therefore should be offered an SGLT2i with proven cardiovascular benefit.	Thank you for your comment. The committee agree that it is very unlikely that anyone with type 2 diabetes is actually at low cardiovascular risk, and this has been highlighted in the rationale for Initial medicines: People with type 2 diabetes and no relevant comorbidities. The title of 'no relevant comorbidities' just shows the treatment that people should be offered if they do not have obesity, chronic kidney disease, early onset type 2 diabetes, heart failure, atherosclerotic cardiovascular disease and frailty. The committee chose not to state SGLT-2 inhibitor with a proven cardiovascular benefit because they agreed that all the drugs in this class have cardiovascular benefits.

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East Sussex Healthcare Trust	Visual summary	General		Under the column CKD, it recommends offering metformin but does not mention dose reduction might be needed depending on renal function	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. Please refer to the committee discussion for details on dose reduction with metformin under the section "People with chronic kidney disease and initial therapy: when can metformin and SGLT-2 inhibitor therapy be given?" and in the "Rationale and Impact" section of the guideline.
East Sussex Healthcare Trust	Visual summary	General		Under the column CKD, there is no reference to the pt being on maximum tolerated dose of ACEi or ARB	Thank you for your comment. Previous recommendations relating to this have been removed for this update because people with chronic kidney disease who are eligible for an SGLT-2 inhibitor (with an eGFR of 20 ml/min/1.73 m ² and above) are discussed in the new medicines recommendations. Stating the maximum tolerated dose of ACEi or ARB is outside the scope of this guideline. Please refer to NICE's information on prescribing medicines .
East Sussex Healthcare Trust	Visual summary	General		Under column CKD, is there the opportunity to mention that glucose lowering effect is reduced if eGFR <45mls/min and other agents may need to be considered in addition	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. Further information is provided in the committee discussion under the session "People with chronic kidney disease: distinction between stages" for the committee's reasoning in not using an eGFR of 45mls/min/1.73m ² .

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East Sussex Healthcare Trust	Visual summary	General		Tirzepatide is not included within the algorithm, however it is referenced in the guideline: "Tirzepatide is recommended as an option in NICE technology appraisal guidance for some adults with type 2 diabetes when it is insufficiently controlled". There is a concern that this may lead to variation in prescribing.	Thank you for your comment. Tirzepatide has now been included in the guideline in relevant places (see recommendations including "GLP-1 receptor agonists or tirzepatide").
East Sussex Healthcare Trust	Visual summary	General		Under the obesity column, the algorithm however states: "Consider adding a GLP-1 receptor agonist" but does not reference specific medications within the class based on weight loss efficacy. Table 1 within the guidance (page 92) refers to "consider adding semaglutide for adults with type 2 diabetes who are living with obesity". Additionally, noting the evidence showed that no GLP-1 receptor agonist reached the cost effectiveness threshold in the base-case analysis for people living with obesity but when price of liraglutide reduced by 35% was used in the sensitivity analyses, there was potential for GLP-1 receptor agonists to be cost effective under specific circumstances should this be considered, should reference be made.	Thank you for your comment. Table 1 has been removed from the guideline as it is only included during the consultation. The committee agreed that no GLP-1 receptor agonist should be specified. While liraglutide came out as cost-effective in one sensitivity analysis, the committee agreed that it did not show evidence of clinically important reductions in weight loss and the evidence for cardiovascular and renal protection and glycaemic benefits was stronger with other GLP-1 receptor agonists. Given this, they did not want to make a specific recommendation and agreed it was more appropriate to provide flexibility in this case.

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East Sussex Healthcare Trust	Guideline	007	018	We felt that the sentence: "who are living with overweight" does not make sense	Thank you for your comment. Living with overweight has been kept in the guideline as it reflects current practice for person centred terminology. This is an area of discussion and so your feedback will be passed to the editorial team for future learning.
East Sussex Healthcare Trust	Guideline	008	011	The word "tobacco" is hyperlinked, but it may be useful to add for recommendations on smoking cessation	Thank you for your comment. The guideline is called "Tobacco: preventing uptake, promoting quitting and treating dependence" and includes recommendations on smoking cessation. Stating the main word that names the guideline is consistent with NICE writing style. Given the recommendation specifies about wellbeing advice, then this allows people to be linked to the relevant advice through this.
East Sussex Healthcare Trust	Guideline	008	016	There is a section signposting to guidance for diagnosis and management of hypertension, but there is not a similar section hyperlipidaemia	Thank you for your comment. This is out of scope for the guideline update.
East Sussex Healthcare Trust	Guideline	013	026	Mentions rtCGM or isCGM	Thank you for your comment. This section is out of scope for the guideline update.
East Sussex Healthcare Trust	Guideline	014	017	There is no mention of metformin within the list of medications	Thank you for your comment. The purpose of this text is to explain that recommendations have been made at the class level (unless otherwise stated) for DPP4 inhibitors, GLP-1 receptor agonists, sulfonylureas and SGLT-2 inhibitors. Drug-level recommendations have been made for metformin, which is why metformin has not been mentioned.
East Sussex Healthcare Trust	Guideline	015	010	It might be helpful to include a recommendation around cost if 2 drugs in the same class are appropriate, to choose the one with the lower acquisition cost	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day

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					to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
East Sussex Healthcare Trust	Guideline	015	018	Reference to GLP-1 RAs, but not dual GIP/GLP-1RA	Thank you for your comment. The committee have assessed the evidence and have agreed that tirzepatide should be included in the recommendation. Therefore, this has been amended to GLP-1 receptor agonists and tirzepatide.

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East Sussex Healthcare Trust	Guideline	015	018	Discusses GLP-1 receptor agonists in those of childbearing potential. Consider including this information under a separate heading or within the section "assessing risks before starting treatment" to improve flow and readability.	Thank you for your comment. We agree that this information is important. This was viewed as a part of conversation with the person while having a medicine discussion, which should always be considered, regardless of whether you are starting the medicine for the first time. Pregnancy, the chance to become pregnant and breast feeding are not a risk associated with type 2 diabetes while cardiovascular disease, worsening renal disease or frailty are and so are listed under 'Assessing risk before starting medicines' (as the latter is related to determining which treatment pathway to use when choosing medicines, while the former would either be offered the same treatment options or be considered in NICE's diabetes in pregnancy guideline). Therefore, we think this is in the right place currently. Thank you very much for your feedback.
East Sussex Healthcare Trust	Guideline	016	001	Section title "Hyperglycaemia", we are concerned that this misses the opportunity to highlight that rescue therapy may need to be considered if the person develops osmotic symptoms, and that insulin and/or SUs should be reviewed once the person is no longer symptomatic and consideration of agents that offer with cardio-renal protection	Thank you for your comment. This section was out of scope for the guideline update. This will be highlighted with the surveillance team as an area for potential update in the future.
East Sussex Healthcare Trust	Guideline	019	005-009	We agree with the recommendation for subcutaneous semaglutide, however, there is evidence to suggest that liraglutide (via LEADER trial), dulaglutide (via REWIND trial) and tirzepatide (via SURPASS-CVOT) also reduce ASCVD events. These should be recommended as an equal choice, or as an alternative for patients unable to tolerate	Thank you for your comment. Of the trials you mention, only the data from REWIND was included in the analysis for people with atherosclerotic cardiovascular disease (ASCVD). The data from LEADER was included in the analysis for people with higher risk of CVD and people with heart failure, and not enough evidence was received for the SURPASS-CVOT trial to assess cardiovascular and renal benefits for tirzepatide in

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				semaglutide, to ensure prescribers are not discouraged from using GLP-1 receptor agonists where appropriate.	people with ASCVD, Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes and ASCVD.
East Sussex Healthcare Trust	Guideline	020	012	People living with obesity. Noting BMI criteria has been removed, should the term be defined within the "terms used in this guideline section" or as per the obesity guideline with reference to "healthy weight". There is a concern that not defining obesity may lead to variations in prescribing. The Tirzepatide TA references BMI.	Thank you for your comment. The sections on initial medicines and treatment options if further medicines are needed for people living with obesity now include cross-references to recommendations on classifying overweight and obesity in NICE's guideline on overweight and obesity management.
East Sussex Healthcare Trust	Guideline	021	006	People with CKD. Within this section is there the opportunity to mention that glucose lowering effect is reduced if eGFR <45mls/min and other agents may need to be added in addition	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .

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East Sussex Healthcare Trust	Guideline	021	008-010	The CANVAS, CREDENCE and CAMPIONE studies demonstrated reduction in the progression rate of CKD in patients with type 2 diabetes and CKD and should be considered alongside empagliflozin and dapagliflozin in this cohort.	Thank you for your comment. CANVAS and CREDENCE trials were included in this review however CAMPIONE was excluded based on the comparator used in the trial (stated as guideline standard of care only). The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .
East Sussex Healthcare Trust	Guideline	023	011	States to introduce the medicines one at a time, starting with metformin and checking tolerability. If using an SGLT-2 inhibitor, start this as soon as metformin tolerability is confirmed. We are concerned that this is not reflected in the algorithm which implies to start together.	Thank you for your comment. The therapy combinations for each population of interest are listed in sequential recommendations with all recommendations regarding introduction of medicines following this information. As all therapy combinations require a stepwise initiation, the recommendations for introducing medicines are listed in a way so as to avoid repetition of the same statements and to avoid confusion. We have added the wording "at the maximum achievable dose" to make it clear when the next medicine should be started. The visual summary states the same points on the first page.
East Sussex Healthcare Trust	Guideline	028	005	People with early onset type 2 diabetes. Recommends "for adults with early onset type 2 diabetes: Offer metformin and an SGLT-2 inhibitor. Consider adding a GLP-1 receptor agonist". Is there the opportunity to expand to include consideration of childbearing potential (and link to guidance)	Thank you for your comment. A recommendation in section Involving people in medicine discussions describes discussing GLP-1 receptor agonists for people of childbearing potential and refers to MHRA guidance on GLP-1 medicines for weight loss and diabetes
East Sussex Healthcare Trust	Guideline	028	005	People with early onset type 2 diabetes. Opportunity to mention targeted education, T2DAY programme	Thank you for your comment. Targeted education is outside of the scope of this guideline update and so will not be discussed.

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East Sussex Healthcare Trust	Guideline	029	011-016	We recommend rewording from 'consider adding' to 'offer' to reduce cardiovascular risk.	Thank you for your comment. We agree that GLP-1 receptor agonists will also provide cardiovascular and renal protection benefits in this case. However, the majority of GLP-1 receptor agonists were not cost effective leading to uncertainty in the recommendation, which led to the consider adding recommendation, instead of an offer recommendation. The committee have recommended that any GLP-1 receptor agonist or tirzepatide can be considered for people in this population given that all available GLP-1 receptor agonists showed glycaemic benefits and some cardiovascular benefits. The most clinically effective was subcutaneous semaglutide which was slightly over the threshold for cost-effectiveness. On the other hand, liraglutide was cost effective but was less clinically effective. Other GLP-1 receptor agonists and formulations of GLP-1 receptor agonists (such as oral semaglutide) were not cost effective and were comparatively less clinically effective. Tirzepatide was shown to be cost effective in the technology appraisal for people with type 2 diabetes but did not have evidence for cardiovascular and renal benefits, which GLP-1 receptor agonists did have. This produced uncertainty in the evidence. Given this, they made a weaker consider recommendation in this case.
East Sussex Healthcare Trust	Guideline	092		Within the table it states "consider adding semaglutide for adults with type 2 diabetes who are living with obesity, if: • they have been taking initial therapy for at least 3 months and • further medicines are needed to reach their glycaemic	Thank you for your comment. Thank you for highlighting this, this has been amended.

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				targets and • they are not already taking a GLP-1 receptor agonist. [2025] (1.8.54)". The algorithm however states: "Consider adding a GLP-1 receptor agonist"- should semaglutide be specifically referenced?	
Education for Health	Guideline	General		We welcome the change in wording in each initial medication category to improve uptake of SGLT-2 inhibitors. The response to this in the professional and general media suggests a significant impact, despite the fact that this has been the recommendation for the overwhelming majority of patients since 2022.	Thank you for your comment. We appreciate your feedback.
Education for Health	Guideline	General		In our experience, dividing 'initial medicines' and 'further medicines' can be confusing for clinicians. There is a risk of information on the overall strategy being missed if there is a need to scroll through multiple pages for the next steps for each patient group. Although the visual summary puts these together, it would be clearer if each patient group had their initial and subsequent medicines specified together, allowing for an overall picture of the medicines guidance.	Thank you for your comment. We acknowledge that dividing 'initial medicines' and 'further medicines' may be confusing. However, if we were to merge these then there would be a mismatch to the structure to the guideline which would also have consequences for the visual summary. Additionally, by combining both initial and further medicines, the sections would become much larger and therefore more difficult to follow.
Education for Health	Visual Summary	General		We welcome the layout of this summary. Although it contains a lot of information, it is clearly laid out and much easier to refer to quickly and follow than the visual summary in the existing guideline.	Thank you for your comment. We appreciate your feedback

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Education for Health	Guideline	007	014	1.3.4 We are disappointed not to see more explicit inclusion of remission as a possible treatment goal for some patients. While the link to the Path to Remission Programme is welcome, this does not provide explicit guidance for clinicians on recommending this approach to patients. We appreciate that the focus is on medicines in this update but as this change has been included it is our view that this is insufficient.	Thank you for your comment. We agree wholeheartedly with you. The committee considered remission throughout the development of the review. Unfortunately, when searching the evidence for medicines, remission was not considered as an outcome of the vast majority of medicine trials. We highly recommend that this is considered for more medicine trials in the future so that we can comment on this as an outcome after treatment for a period of time in the future. A cross-reference link has been added to the NHS Pathways to Remission programme which can be used to access eligibility and referral thresholds. A cross reference has also been added to recommendations on low-energy and very-low-energy diets to achieve type 2 diabetes remission which was considered as part of the update of the overweight and obesity management guideline (NG 246).
Education for Health	Guideline	008	023	1.6 It is unclear why this is included in the guideline as it is neither common practice, nor a recent change in guidance.	Thank you for your comment. This is out of scope for the guideline update.
Education for Health	Guideline	008	026	1.6.2 It is unclear why this important recommendation is in a subsection entitled antiplatelet therapy.	Thank you for your comment. This is out of scope for the guideline update.

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Education for Health	Guideline	010	016	1.7.8 This largely unchanged statement has been a source of confusion for clinicians, particularly those with less experience, for some time. The previous section recommends targets of 48 mmol/l and 53 mmol/l, but the wording of this appears to suggest that 57 mmol/l is an acceptable target. We accept that this an attempt to give some pragmatic advice about thresholds for change, however in our opinion, it is contradictory and unhelpful. This is particularly the case given that the vast majority of our patients are no longer on medicines with a risk of hypoglycaemia, and therefore the evidence supports a target of 48 mmol/l. We are concerned that this recommendation contributes to the risk of clinical inertia, particularly in patients with the most to gain from good glycaemic control.	Thank you for your comment. This section was amended for updating language only and was out of scope for this guideline update. The committee agreed that these targets should be individualised. This is discussed in the recommendations after this that mention NICE's patient decision aid on type 2 diabetes: agreeing someone's blood glucose (HbA1c) target. This has been reinforced later in the guideline when discussing reviewing medicines to make this clearer. The committee does not want to set values for HbA1c as they do not have evidence to support this and do not believe this will be the best for care. Given this is a personalised goal it is up to the person with diabetes and their healthcare professional to decide whether they want to expand that range. The patient decision aid related to the guideline is available to support this.
Education for Health	Guideline	018	005	1.8.10 We welcome the recommendation to offer modified-release metformin but have concerns about the wording. The reference to adherence can be stigmatising and there is no mention of tolerance. This comment applies to this recommendation in each section.	Thank you for your comment. Following committee discussion, the committee agreed that modified release metformin would have better tolerance and subsequent adherence than standard-release metformin. Therefore, we have updated the recommendations to recommend modified-release metformin as first line for all people prescribed metformin.

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Education for Health	Guideline	024	014	1.8.38 We would prefer to see this worded in the language of shared decision-making with patients.	Thank you for your comment. We agree that the wording could be clearer and have amended the text accordingly.
Education for Health	Guideline	025	004	1.8.40 We welcome the inclusion of a section specifically on reviewing metformin. We would like to see the inclusion of advice to continue at whatever dose is tolerated since clinical experience shows that many patients who have stopped metformin due to intolerance can tolerate a smaller dose if re-introduced with care.	Thank you for your comment. We have added wording about achieving the 'maximum tolerated dose' into the "How to introduce medicines" section which now achieves this. We have also changed the metformin formulation to modified-release metformin for most people, which will also likely reduce the number of people who have intolerance to it.
Education for Health	Guideline	026	014	1.8.46. We are concerned to see no option for GLP-1 therapy in this group, and the inclusion of insulin therapy in preference in particular. Many people who do not meet the requirements for a diagnosis of obesity are nonetheless significantly overweight. The addition of sulphonylureas or insulin in this group is not advisable where weight management is a concern, and the considerable implications of insulin use make this less suitable for most patients. In addition, the majority of people with type 2 diabetes and no existing comorbidity are at high cardiovascular risk in the future and we would like to see the option to manage this risk in advance, rather than waiting until cardiovascular disease has developed. This recommendation is contrary to the new NHS 10 year plan, with its stated focus on prevention.	Thank you for your comment. We have reviewed the evidence for this group, and it was found to not be cost effective. Therefore, it has not been recommended. This is in line with NICE's role to make recommendations to help get the best care to people, fast while ensuring value for the taxpayer.

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Education for Health	Guideline	030	013	1.8.57 We consider this information insufficient to support prescribing decisions. The guidance on tirzepatide in the linked technology appraisal is minimal and leaves many questions unanswered. Despite this, there is significant clinical use of tirzepatide and in our view, NICE has a responsibility to provide guidance on its use.	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist and tirzepatide" to show the role of tirzepatide in this population. Otherwise, we recommend referring to the BNF for information about the use of tirzepatide.
Education for Health	Guideline	072	001 002 007	The evidence summary rightly states that insulin is general only advisable in managing acute hyperglycaemia and hyperglycaemia that does not respond to other treatments. However the guideline overall places insulin ahead of GLP-1 and similar therapies for some groups of patients who do not meet this criteria. It is not clear why DPP-4 inhibitors are specifically identified for tolerance issues.	Thank you for your comment. There is insufficient evidence to place GLP-1 receptor agonists and tirzepatide currently, therefore we have not commented on them. This is different from placing it behind insulin, where the benefits and flaws are well known and understood. They are highlighted for people who cannot tolerate DPP-4 inhibitors because they are included in a recommendation that makes an explicit statement that they are a subsequent treatment for people who cannot tolerate DPP-4 inhibitors.
Education for Health	Guideline	089	003	Table 1: Deleted recommendations item 3. Despite the correct information that this information is in the British National Formulary (BNF), clinical experience suggests that this advice is often not followed. As metformin is very commonly used, it is our view that clinicians are less likely to consult the BNF when prescribing. We would like to see this recommendation retained in the guidance to offer as many opportunities as possible for clinicians to be exposed to this recommendation.	Thank you for your comment. We appreciate your concerns. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC

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					for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC). In general, NICE avoids recommending specific doses unless strong evidence of clinical and cost-effectiveness is found for doses outside of the BNF prescribing information. The recommendations in the reviewing medicines section highlight the importance of reviewing treatment regimens (including dosing).
Eli Lilly & Company Ltd	Economic Model	General		Factual accuracy in the UKPDS Outcomes Model 2 Semaglutide cost There is an error in the semaglutide cost entered in the "Model Parameters" sheet, cell K35. The annual cost is entered as GBP 936.99, whereas the correct annual cost is GBP 955.52 (73.25 / 28 *365.25). This will impact the cost-effectiveness results for semaglutide and may lead to an underestimation of the ICERs.	Thank you for your comment. The annual cost of subcutaneous semaglutide has been revised. This update did not lead to a significant change in its cost-effectiveness and the recommendation has remained the same.
Eli Lilly & Company Ltd	Economic Model and NMA	General		Use of the UKPDS Outcomes Model 2 and Network Meta-Analysis In addition to the discussion on the guideline, Lilly would like to provide commentary on the UKPDS Outcomes Model 2 that was used by NICE to generate economic analyses, and the network meta-analyses (NMAs) used to inform the guideline.	Thank you for your comment. We address each point separately below. Use of the UKPDS Outcomes Model 2 and Network Meta-Analysis The committee wanted to consider whether moving several treatments further up the treatment pathway would be effective and cost-effective. To allow full consideration of this all treatments had to be considered simultaneously. The

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				The cost-effectiveness model is driven by the outcomes informed by the results of the NMAs, however, there are weaknesses in both how the NMAs have been conducted and used in the cost effectiveness analyses. The underlying premise of the health economic analysis is flawed, as the analysis aims to compare all diabetes treatments with each other simultaneously in a range of populations, implying that all treatments are simultaneously viable options for a given patient. In practice, clinicians are not choosing interventions in this manner, instead using a treatment algorithm to select appropriate treatments for patients as the disease progresses. The issues highlighted related to both the NMA inputs informing the economic model and the long-term assumptions on HbA1c progression, weight, and treatments costs mean that the model is inherently biased against the most effective medications. NICE's position on the use of disease-specific reference models in economic evaluations Lilly welcomes NICE's recently published approach to looking at reference models in economic evaluations,²² however, have some concerns with the applicability of the UKPDS model to NICE's position, in particular around the adaptability of the model and the lack of ease of use for stakeholders.	committee wanted to move away from an approach that only considered treatments (including SGLT-2 inhibitors and GLP-1 receptor agonists) after other treatments had failed. NICE's position on the use of disease-specific reference models in economic evaluations Your concerns have been noted and shared with the relevant team. NICE will prioritise topics for future reference case extensions. Network meta-analysis Data from the REWIND trial for a subgroup of people with ASCVD was included for the outcome of 3-item MACE for people with type 2 diabetes and ASCVD. Data from the whole study population for REWIND was also included in the higher risk for CVD population along with the data from SUSTAIN 6 and PIONEER which had mixed populations also. We could not assess the SURPASS-CVOT trial, as we did not have sufficient evidence to support assessment of the clinical effectiveness of tirzepatide. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness for cardiovascular and renal protection. Between study heterogeneity analysis was assessed for the NMAs using both deviance information criterion (DIC) and comparing the fit for both the random effects and fixed effects models. The small difference in DIC between the random and the fixed effects for each outcome suggested that the fit

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				This is due in part to the age of the model and the issues presented below. Lilly would welcome the review of alternative models as the reference case for type 2 diabetes in light of NICE's new position. Network meta-analysis The rationale for allocation of studies to each population-specific evidence base is unclear. REWIND was included in the atherosclerotic cardiovascular disease (ASCVD) evidence, but SUSTAIN 6, PIONEER 6 and LEADER were included in the high risk of cardiovascular disease (CVD) evidence. This is despite REWIND enrolling a lower-risk population (31% with prior CVD) compared with SUSTAIN 6 (60% with prior CVD), PIONEER 6 (85% with prior CVD) and LEADER (81% with prior CVD). These trials populations are however generalisable to UK clinical practice, with the population of REWIND being more representative of the UK type 2 diabetes population than LEADER or SUSTAIN-6 with regard to both CV and combined CV/core eligibility criteria.²³ The similarity between the trial data and the outputs of the NMAs suggest that very minimal adjustments are being made for differences in baseline characteristics of the populations or other sources of heterogeneity in the trials. The cardiovascular outcomes trials (CVOTs) are not comparable, due to differences in enrolled populations, duration,	obtained by adding the random effect did not justify the random complexity. The committee noted the imprecision in the NMA findings due to the large number of comparisons where zero event data was available in one arm but agreed that using the composite outcome of MACE to aid decision making was a way of dealing with this limitation. MACE treatment effects were not included in the economic model. MACE outcomes were considered qualitatively by the committee when assessing the cost-effectiveness evidence especially in interventions and populations where there was no evidence identified, evidence had been borrowed from alternate populations or where outcomes for individual cardio-renal events did not concur with the MACE outcomes. Network meta-analysis: issues with utilisation in the cost-effectiveness analysis The committee discussed the transferability of treatment effects between populations and agreed that it was reasonable to assume that they were transferable across different populations in the absence of evidence. Regarding the calibration of the model, the approach is described in sections 2.2.2 and 2.2.3. Please note the following: 'The model was therefore run twice. The first iteration of the model adjusted for NFCVE (non-fatal cardiovascular events), HbA1c and weight. A calibration factor

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				standard of care and endpoint definitions. There appears to have been minimal adjustment for these differences, with hazard ratios used in the modelling analysis very similar to those observed in the CVOTs. This is likely to bias the analysis against dulaglutide as REWIND was conducted in a relatively low-risk population. The NMAs calculated hazard ratios for each endpoint individually in order to allow separate modelling of the endpoints of interest. However, in the CVOTs, the power calculations to select the number of participants and the study durations were based on expected frequency of major adverse cardiovascular events (MACE) in the study populations. Therefore, the trials were not powered to detect differences in the individual components of MACE, or the other endpoints included in the modelling analysis (such as heart failure [HF]). As the modelling analysis used separate hazard ratios, the CVOTs are being used in a way that was not intended in the trial design, and therefore some of the clinical efficacy inputs used in the analysis may result from the inadequate powering to detect differences. Network meta-analysis: issues with utilisation in the cost-effectiveness analysis Where data were not available from the NMA specific to the population of interest for an	was than calculated for CVM that would bring the results from the first run of the model in line with those predicted by the accompanying NMA. A second and final run of the model was then undertaken adjusting NFCVE, weight and HbA1c as per the first run but with CVM adjusted using the calibration factor.' The first iteration of the model run was used to calibrate non-fatal cardiorenal events to the expected rates from the NMA and also capture the model-predicted cardiovascular mortality (CVM) that follows. The second run of the model aimed to calibrate the CVM to that predicted in the NMA. Regarding the suitability of metformin as a comparator, the committee reviewed CPRD data related to uptake of pharmacological treatments across all populations. The data showed that a single pharmacological treatment was most commonly prescribed across all populations. The data also showed that of all pharmacological agents, metformin was most frequently prescribed. The committee therefore agreed that it was appropriate to model metformin monotherapy as the comparator and add various interventions to it in the analysis. Treatment intensification and discontinuation While previous models have used a mean glycated haemoglobin value of 7.5% as the point at which treatment is intensified, the committee were keen to move away from this model in light of treatments that show evidence of cardiorenal

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				intervention, the modelling analysis used inputs from another population. This used the hierarchy: High risk of CVD > ASCVD > HF > chronic kidney disease (CKD). This transferability of data between populations has not been justified. Related to this, the odds/hazard ratios from the NMAs are being applied to patient populations from the Clinical Practice Research Datalink (CPRD). The CPRD patients are very different to those enrolled in the CVOTs, being notably older and with lower baseline HbA1c on average. Hazard ratios may not be transferable between populations. Calibration of models with multiple interlinked complications is difficult due to competing risk. For example, the incidence of myocardial infarction modifies the risk of mortality impacting life expectancy, and the life expectancy impacts the risk of all complications, including myocardial infarction. The order in which the calibration is conducted can have a large impact on the results. The health economic report describes a range of methods for calibration of the cost-effectiveness model to the NMA outcomes. However, the final approach used in the modelling analysis is not described. The calibration is applied to a metformin arm modelled based on conventional risk factors. However, the model performance in each of the	protective effects. These treatments are therefore not being prescribed solely to control HbA1c. However, as you correctly note, in practice, they may not be suitable in individuals with 'very low HbA1c'. While not included in the modelling, the guideline has included recommendations for intensification where current medicines haven't worked. Treatment discontinuation was incorporated into the model using real-world data in the base case (see Table 23 of the health economic report). A sensitivity analysis also explored the impact of using discontinuation data from RCTs (see Section 2.4.4). Treatment initiation The committee discussed whether it was appropriate to model treatment intensification linked to a fixed HbA1c threshold, as is commonly modelled. However, they were strongly against this approach as they explained that best practice has moved away from glycaemic centred management to a holistic approach that looks at patient co-morbidities and other risk factors like weight. They attempted to mimic these in their chosen populations to be modelled. HbA1c progression As noted above, the committee decided to move away from the intensification approach during modelling as they thought it

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				modelled populations is not validated. Furthermore, it is unlikely that metformin monotherapy is a suitable therapy option in the relatively progressed patients modelled. For example, in the ASCVD analysis, mean duration of diabetes across the 200 simulated patients was 11.5 years (minimum 1 year, maximum 32 years). Any inaccuracies in this analysis feed through to all other simulations prepared. Treatment intensification and discontinuation Not all modelled patients are candidates for intensification of treatment. In the atherosclerotic cardiovascular disease cohort, the mean glycated haemoglobin (HbA1c) is 7.4%, with a minimum of 4.2%, and 42% of patients having an HbA1c below 7%. It is unlikely that patients with very low HbA1c values will receive a new medication, and that the HbA1c change calculated for each intervention listed by the model would be seen in clinical practice. Patients do not discontinue medications in the model, and are not modelled to receive additional treatments. This is not aligned with the progressive nature of type 2 diabetes, and the recommendations around stepwise initiation of additional treatments in treatment guidelines. This implies that patients would stay on metformin for the duration of their lifetime without addition of	was important to consider a more holistic approach to management. Assumptions on weight regain/loss In the base case analysis, weight reduction was assumed to revert to baseline after 5 years, which was the committee's preferred assumption as it followed their clinical experience. However, the committee acknowledged that this is an area of uncertainty, with published data from randomised-controlled trials beyond 18 months not available to them. A sensitivity analysis was therefore conducted whereby the weight-reducing effects were assumed to persist for a lifetime, even if individuals discontinued treatment. The application of the Bagust and Beale 2005 calculation has been revised following consultation and now follows the more conventional approach outlined. Regarding the weight loss effects themselves, these were obtained from the clinical review NMA in year 1 and CPRD data in years 2-5. The assumption of a delayed progression of weight rebound with SGLT-2 inhibitors relative to GLP-1 receptor agonists was informed by the committee's clinical experience. The time taken for rebound (1 year with GLP-1 receptor agonists and 2 years with SGLT-2 inhibitors) were chosen as these were the smallest numbers that could be

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				further medications, which does not reflect real-life practice. Treatment initiation It is likely that initiation of medications will be faster with less effective interventions. This was observed in REWIND, where glycaemic intervention was required sooner with standard of care than dulaglutide. Costs as a result of initiation of new medications have not been captured in the analysis prepared by NICE, underestimating the costs associated with less effective interventions. HbA1c progression The HbA1c progression (following the UKPDS 90 equation) is not aligned with clinical practice. In the model, HbA1c increases fastest with the most effective interventions such that the differences between the treatment arms are abolished, with HbA1c trending towards 10%. This is not aligned with modern treatment, with intensification to maintain glycaemic control (related to the point above). As the model assumes that patients receive treatments for the duration of their lifetimes, costs are therefore incurred for the duration of the patient's lifetime whilst the clinical benefit of treatment is lost in the long-term, leading to inflated costs and underestimation of cost-effectiveness,	modelled given annual model cycles that would exhibit the differential expected by the committee. Risk factors HbA1c and weight were the only risk factors included in the model. These were the factors identified as most relevant in the review protocol and that could be adapted within the UKPDS model. The omission of other risk factors are unlikely to significantly alter the model outcomes given that the model was calibrated to key cardio-vascular and renal outcomes from the NMA. Impact of UKPDS Outcomes Model 2 on ICERs The committee considered several models but ultimately chose the UKPDS model. We acknowledge the model has some limitations which are highlighted in the discussion section. The model results were calibrated to the NMA outcomes, which is a form of validation in and of itself. We have applied a disutility for weight gain (and by association a utility increase for weight loss) in the base-case. This uses values from Bagust & Beale 2005 and is identical in line with the approach used in economic modelling for the previous update of this guideline. We have conducted various sensitivity analyses with more favourable assumptions around weight loss and the committee considered these results when deliberating the cost-effectiveness of different interventions.

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				more heavily penalising the more effective therapies. Assumptions on weight regain/loss Weight regain is included in the model for all patients, where it is modelled from years 2–5 is based on CPRD data, which assumes that all patients in the model gain weight even whilst on treatment. This means that effective weight management therapies, such as tirzepatide, are incorrectly modelled, as clinical trial data show no weight regain for 3–4 years whilst on treatment. This underestimation of the treatment effect unfairly underestimates the cost-effectiveness of these newer innovations in weight management for type 2 diabetes patients. The modelling analysis assumes that patients receive treatments for the duration of their lifetimes, but that weight increases to baseline after 5 years. This means that costs are incurred for the duration of the patient's lifetime, however the benefit of weight reduction from treatment is only observed during the first five years and is lost in the long-term, which, similarly, to point above, has a greater impact on underestimating the cost-effectiveness of the more effective weight management therapies. The assumption of increased weight while still receiving initial therapies is not aligned with the trial evidence. While weight has been shown to increase	

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				when glucagon-like peptide-1 receptor agonist (GLP-1 RA) therapy is stopped, all evidence from long-term trials such as REWIND and SUSTAIN-6 in type 2 diabetes, and SURMOUNT-1 3-year extension data in obesity, suggest that weight reductions are maintained while treatment is continued and suggest that would not return to baseline immediately after 5 years. The model assumption is also not aligned to the results observed in SURPASS-CVOT, where weight loss was maintained to Week 156.¹² Within the model, the weight of a patient has limited long-term impact on health-related quality of life, due to how weight-associated utilities are adjusted: whilst the conventional approach for weight disutility uses a calculation based on a patient's current BMI compared to a healthy BMI of 25 (Bagust and Beale 2005),²⁴ NICE's approach follows a similar calculation but uses the patient's BMI from the previous year as a basis. This means that in the model, after Year 5, when a patient's BMI is tracking parallel for all interventions, but is notably lower with GLP-1 RAs and sodium-glucose co-transporter-2 inhibitors (SGLT-2is) than with insulin, pioglitazone or dipeptidyl peptidase 4 inhibitors, there is no utility benefit shown relative to the greater decrease in BMI.	

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				Therefore, maintaining differences in weight and the subsequent quality of life difference could have a substantial impact on the model analysis. Additionally, in the model, the weight loss modelled for SGLT2i treatments shows a greater reduction in body weight than for modelled GLP-1 RAs, as well as a slower weight regain, which is inconsistent with all available evidence from clinical trials, that show that GLP-1 RAs have a greater effect on body weight reduction than SGLT2is. This means that the modelled ICERs for GLP-1 RAs will be misrepresented and underestimated in comparison with SGLT2is. Risk factors HbA1c and weight were the only risk factors included in the model. Other modifiable risk factors such as systolic blood pressure, serum lipids, and heart rate were not included. Therefore, interventions associated with a wide range of additional benefits, such as GLP-1 RAs, are undervalued. Impact of UKPDS Outcomes Model 2 on ICERs These points have been highlighted from the perspective of awareness, and Lilly would like to note that due to these reasons the economic results from the UKPDS Outcomes Model 2 should be considered as highly conservative based on current	

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				interpretations, where the impact of effective management of weight is of high importance and is not captured in the model. In light of this, validation using an alternative economic model, such as the CORE Diabetes Model, or the PRIME type 2 diabetes model that was accepted as a credible tool by NICE in TA924,¹ would allow NICE to test the robustness of the UKPDS results and may provide insight into how differing model assumptions impact the ICERs.	
Eli Lilly & Company Ltd	General			Lilly welcomes the updates made to NICE guideline NG28, noting the progressive steps made towards a more holistic approach to treating all the relevant facets of type 2 diabetes and its comorbidities, beyond a singular emphasis on glycaemia, alongside a greater focus on patients. Whilst Lilly acknowledges these positive steps that have been taken, Lilly would like to highlight some potential oversights in the updated pathway, and the differences when comparing to the recommendations made in the technology appraisal guidance for tirzepatide (TA924). In TA924, highly efficacious weight management medications were recommended where weight loss would be beneficial, and tirzepatide was considered as a more cost-effective treatment option than glucagon-like peptide-1 receptor agonists (GLP-1 RAs); and	Thank you for your comments and support of the update. As you have correctly stated, tirzepatide showed clinically important reductions in HbA1c and weight change outcomes. We have not identified nor received sufficient evidence to state that it has shown evidence of cardiovascular and renal protection. Given this, it has not been recommended for cardiovascular and renal protection and has not been recommended where similar therapies are being recommended specifically for these benefits and have been shown to be cost effective . Instead, the committee agreed to recommend it in line with GLP-1 receptor agonists when recommending it for glycaemic benefits (people living with obesity) or where there is uncertainty about the cost effectiveness and no specific GLP-1 receptor agonist has been identified as superior over another (people with early onset type 2 diabetes, in this scenario it has been made clear why the treatment should be recommended based on the current

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				therefore, was recommended for routine use in the NHS.¹ To support NICE in their endeavour to create a useable and useful guideline document, Lilly have provided data and evidence for tirzepatide as a therapeutic option for type 2 diabetes patients, and have also presented supporting data for tirzepatide in type 2 diabetes patients with comorbid cardiovascular disease or heart failure. Type 2 diabetes treatment pathway Lilly acknowledges the positive steps made in the inclusion of additional categories/comorbidities that should be considered within the treatment pathway and welcome the shift of focus to wider outcomes beyond glycaemia. However, Lilly would like to highlight that these comorbidities have been siloed within the guideline, whereas in clinical practice these categories overlap significantly. The guideline in its current form does not offer clarity on how treatment options would be selected or prioritised in a way that is immediately clear to busy healthcare professionals, and may lead to contradictory guidance for some comorbidities. Lilly suggests that the guidance be updated to clearly recommend how comorbidities, such as obesity, should be prioritised to ensure that those	evidence). Where GLP-1 receptor agonists have been included, recommendations have been adjusted so that the wording is "GLP-1 receptor agonist or tirzepatide" to acknowledge the place where tirzepatide could be considered for its glycaemic reducing effects and the beneficial side effect of reducing weight in line with how it was approached in TA924. Type 2 diabetes treatment pathway The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it was most important to make recommendation based on the evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. However the committee agree with your assessment of multiple comorbidities. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to advise people to account for: a) medicines required for cardiovascular and renal protection, b)

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				patients receive the most effective treatment options. Weight management targets Lilly welcomes the advancements made in the development of the updated guidelines in the inclusion of comorbidities, as well as the consideration of outcomes beyond glycaemia. However, Lilly would like to note that the treatment goals listed by the guideline still appear to remain based on glycaemia. Specific weight targets for multiple categories of comorbidities appears to have been omitted from the guideline, and are not currently included for people with type 2 diabetes and obesity, where weight targets are of high importance given the nature of the disease and the prevalence of weight-related comorbidities.²⁻⁶ The American Diabetes Association (ADA) and European Association for the Study of Diabetes (EASD) 2022 Consensus Report highlights the importance of weight loss for outcomes in type 2 diabetes, suggesting that weight loss of 10–15% or more can have a disease-modifying effect and lead to remission of diabetes, and that weight loss may improve risk factors for cardiometabolic disease and quality of life, beyond management of glycaemia alone.⁷ Lilly therefore suggests weight targets be considered as equally important as glycaemic	medicines that are contraindicated, c) medicines optimisation especially for people with frailty. Further information can be found in the committee discussion document. Weight management targets Mention of weight management targets have been removed from the medicine section of the guideline apart from one recommendation about considering continuing treatment if it helps people to achieve their glycaemic and weight management targets. A 2009 recommendation is in the guideline discussing a suggestion of an initial target with a suggestion that a target of any amount, even a small amount can be beneficial. Weight management targets are discussed in NICE's guideline on overweight and obesity management [NG246], which has more information on agreeing weight management goals for someone with type 2 diabetes, which is cross referred to earlier in the guideline when discussing making individualised targets for weight management. The committee were unable to make recommendations about specific weight loss targets as this is out of scope for the update and they did not review evidence for this. We will pass on the suggestion to look at weight management targets in subpopulations of people with type 2 diabetes to NICE's surveillance team. Management of people living with type 2 diabetes and overweight (please note: conditions are managed rather than

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				targets and be included in the guideline, along with recommended timeframes to achieve these. In addition to this, highly efficacious weight management medications should be considered as first-line in the treatment pathway in order to more effectively manage weight targets for people living with type 2 diabetes and obesity.¹ Management of people living with type 2 diabetes and overweight Although Lilly welcomes the categorisation of comorbidities in the treatment pathway, there is currently no category in the guideline or recommendations for the treatment of people with type 2 diabetes living with overweight despite a target of 5–10% weight reduction within the guideline text. As overweight is not covered by the obesity category, these people would appear to fall into the 'no additional comorbidities' category; the treatment pathway proposed in the draft guidance would therefore be suboptimal for their condition. None of the proposed treatment options after SGLT2i in the 'no additional comorbidities' algorithm support weight loss; conversely, some are known to cause weight gain. Additionally, clarity in the recommendation of treatment options and their order would be of importance, to allow clinicians to be able to consider and prioritise weight	people, the wording is maintained for clarity of which subheading we are referring to) The health economic modelling showed that none of the GLP-1 receptor agonists were cost-effective in people with type 2 diabetes at high cardiovascular risk living with overweight. Therefore, the committee were unable to recommend GLP-1 receptor agonists in this population. Management of people living with type 2 diabetes and obesity (please note: conditions are managed rather than people, the wording is maintained for clarity of which subheading we are referring to) The committee were clear that diabetes management should aim at holistic health improvements (in particular cardiovascular and renal protection). The rationale and impact section describes that the health economic modelling found that SGLT-2 inhibitors were cost-effective and were found to be more clinically effective at reducing cardiovascular events than any other therapy combining metformin with one other medicine for the wider population. People with a BMI of 35 kg/m² (or lower thresholds for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family backgrounds) who have type 2 diabetes may be eligible for treatment with tirzepatide or semaglutide for managing obesity based on TA1026 and TA875 if weight loss is their primary treatment aim.

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				management alongside the treatment of other comorbidities. Lilly requests that the treatment of people with type 2 diabetes and overweight be considered as a separate comorbidity within the guideline. Management of people living with type 2 diabetes and obesity Lilly welcomes the recommendation of more effective therapies (metformin plus a sodium-glucose cotransporter 2 inhibitor [SGLT2i]) earlier in the treatment pathway for people living with obesity, however there are concerns regarding the use of these therapies as the first-line treatment in clinical practice in the UK when effective treatment options such as GLP-1 RAs and tirzepatide, which has allowed patients to achieve body weight reductions of 10–15%, are available.^{8,9} Starting these patients with metformin and an SGLT2i is unlikely to achieve the level of weight loss that would be clinically meaningful (10–15% reduction) as suggested by the ADA/EASD Consensus Report. Therefore, the first choice of therapy should be reconsidered in favour of efficacious weight management medications for patients with type 2 diabetes and obesity.⁷ Tirzepatide has demonstrated significant benefit for people living with type 2 diabetes and obesity, through its proven efficacy and a robust evidence	Both SURPASS-2 and SURMOUNT trials were included in the guideline. Tirzepatide showed clinically important reductions in HbA1c and weight change outcomes, however there was insufficient evidence to state that it has shown evidence of cardiovascular and renal protection. Given this, it should not be recommended ahead of therapies that do have benefits in cardiovascular and renal protection and have been shown to be cost effective for this reason and should be in line with the other GLP-1 receptor agonists. The recommendation for second line therapy has been adjusted so that the wording is “GLP-1 receptor agonist or tirzepatide” to acknowledge the place where tirzepatide could be considered for its glycaemic reducing properties and potentially beneficial side effect of reducing weight in line with how it was approached in TA924. Management of people with type 2 diabetes and atherosclerotic cardiovascular disease The visual summary has been updated to make it clearer that therapies are to be initiated sequentially. Not enough data was received from the SURPASS-CVOT trial to assess cardiovascular and renal protection for tirzepatide. Therefore subcutaneous semaglutide was the only medicine out of the GLP-1 receptor agonists and tirzepatide that we identified and received sufficient material to review that showed clinical and cost effectiveness to indicate cardiovascular and renal protection and glycaemic and

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				base in glycaemic control and weight reduction within the SURPASS and SURMOUNT trial programmes.^{10, 11} Lilly would propose that more efficacious weight management medications be considered as first-line treatment options for people with type 2 diabetes and obesity. Management of people with type 2 diabetes and atherosclerotic cardiovascular disease Although the recommendation of more effective treatment options for the first-line management of cardiovascular disease in people with type 2 diabetes is a positive step forward, clinical advisors have suggested that in practice clinicians will rarely prescribe a triple therapy at first line due to tolerability concerns. Whilst the guideline text provides some clarity on how the recommended therapies should be staggered this is unclear in the algorithm, which is likely to be the first reference point for busy HCPs. The committee noted that semaglutide was recommended over other glucagon-like peptide-1 receptor agonists for the treatment of patients with type 2 diabetes and atherosclerotic cardiovascular disease based on the availability of evidence presented and cost-effectiveness.	benefits, and potential beneficial side effects of weight loss for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather than tirzepatide, for people with atherosclerotic cardiovascular disease at this time. Management of people with type 2 diabetes and heart failure For the heart failure population, subcutaneous semaglutide was the most cost-effective intervention with an ICER of £10k per QALY (base-case analysis). These cost-effectiveness estimates were derived from input values from the population of people with high risk of cardiovascular disease; data from the STEP-HFpEF DM was included for two outcomes. On reflection, this recommendation has been removed as the dose used in the STEP-HFpEF DM trial was the dose for weight management (2.4 mg weekly) and in balancing the factors together, it was agreed that further evidence was required before making a specific recommendation for people with heart failure. However, people with heart failure living with obesity (the population seen in the STEP-HFpEF DM trial) would be able to access GLP-1 receptor agonists or tirzepatide through the recommendations for people living with obesity if this comorbidity is prioritised when considering therapies for further management of glycaemia if there are no reasons for them take a GLP-1 receptor agonist or tirzepatide.

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				Lilly would like to note that recent positive outcomes have been published during the consultation period for this draft guideline from the SURPASS-CVOT trial for tirzepatide.¹² Management of people with type 2 diabetes and heart failure Lilly would like to highlight that although specific doses are not recommended by NICE in the treatment pathway, NICE have not presented data for semaglutide 1.0 mg, the licensed dose for patients with type 2 diabetes that is available on the NHS, as the basis of their recommendation of semaglutide in the treatment of heart failure in people with type 2 diabetes. Tirzepatide has shown positive reduction in the risk of heart failure outcomes and weight loss results from the SUMMIT trial,¹³ which, although designed to explore heart failure with preserved ejection fraction (HFpEF) in patients with obesity (with or without type 2 diabetes), used doses of tirzepatide that are already licensed and recommended for both type 2 diabetes and weight management, and therefore would be available on the NHS for type 2 diabetes patients with heart failure. As of 24th September 2025, data for tirzepatide in patients with HFpEF and obesity from the SUMMIT trial have been included in 'Section 5.1:	Use of the UKPDS Outcomes Model 2 and Network Meta-Analysis As noted in the HE report, a limitation of the modelling approach was that where there was no evidence of treatment effectiveness, we conservatively assumed a hazard ratio of 1, even where the committee would expect to observe a treatment benefit. This approach was adopted to make the selection criteria uniform and relatively free from bias. In moving to a modelling approach that prioritises calibrating cardiorenal model results to those observed in trials, it is assumed that the effects of weight loss on those model cardiorenal outcomes effects are indirectly captured, since both would be expected to occur concurrently and not independently. We also incorporated a utility score directly associated with weight change, independent of the utility values linked to other model outcomes.

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				Pharmacodynamic properties' of the tirzepatide summary of product characteristics.⁸ Evidence to support the use of semaglutide in this population is taken from trials that use a dosage that is not licensed for the treatment of type 2 diabetes (subcutaneous semaglutide 2.4 mg),¹⁴ which is only recommended by NICE for the treatment of obesity in specialist weight management services, and therefore would not be available on the NHS for the treatment of patients with type 2 diabetes and heart failure, and notably cannot be prescribed within primary care in the NHS.¹⁵ As no evidence has been presented for semaglutide 1.0 mg in type 2 diabetes and heart failure, and as semaglutide 2.4 mg is not licenced for the treatment of type 2 diabetes in the UK, Lilly would strongly suggest that semaglutide not be included in the recommendation for patients with type 2 diabetes and heart failure. Use of the UKPDS Outcomes Model 2 and Network Meta-Analysis In addition to the discussion on the guideline, Lilly would like to note that due to various assumptions made in the modelling of type 2 diabetes and in the network meta-analysis used to inform these decisions, that the economic results from the UKPDS Outcomes Model 2 should be considered	

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				as highly conservative. This is primarily due to the fact that the impact of effective management of weight is of high importance and is not captured in the model, with the assumptions used unfairly penalising innovative therapies, that are shown to provide greater benefit in clinical trials that is not reflected in the model results. The results generated using the UKPDS Outcomes Model 2 should be validated by using alternative diabetes models, such as the CORE Diabetes Model or the PRIME T2D model.	
Eli Lilly & Company Ltd	Guideline	General		Type 2 diabetes treatment pathway Lilly acknowledge the advancements made in the inclusion of additional categories/comorbidities that should be considered within the treatment pathway and welcome the shift of focus to wider outcomes beyond glycaemia. Lilly agrees with the decision to recommend adoption of an individualised approach to type 2 diabetes care and the recommendation to involve patients in the discussions around their treatment to guide them to informed decisions. Lilly recognises the need to categorise patients' comorbidities and welcomes the inclusion of early-onset type 2 diabetes, however, Lilly would like to highlight that the comorbidities have been siloed within the guideline, with recommendations for the management described on a per-comorbidity basis,	Thank you for your comment. We appreciate that this is an area of uncertainty and have provided additional wording and recommendations to help support decisions about this. Ultimately, the person with the condition is the expert in knowing what matters to them, while the healthcare professional is the expert of knowing what medicines are appropriate given the clinical scenario. Using their experience together on a case by case situation they are able to come up with a plan and work on this together. The guideline provides evidence-based recommendations based on how the studies were conducted to support this. However, putting this together should be based on a holistic approach that takes into account

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				whereas in reality these categories of comorbidities will overlap significantly. The guideline in its current form does not offer immediate clarity on how treatment of multiple comorbidities would be selected or prioritised – such guidance should be included upfront alongside the core recommendations and within or alongside the treatment pathway figure, in a way that is immediately clear to busy healthcare professionals. Lilly suggests that the guidance be updated to clearly recommend how comorbidities, such as obesity, should be prioritised, to ensure that those patients receive the most effective treatment options.	the person's needs and views about their care with the expertise of their healthcare professionals. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to advise people to account for: a) medicines required for cardiovascular and renal protection, b) medicines that are contraindicated, c) medicines optimisation especially for people with frailty. Further information can be found in the committee discussion document.
Eli Lilly & Company Ltd	Guideline	General		Weight management targets Lilly welcomes the advancements made in the development of the updated guidelines in the inclusion of comorbidities, as well as the consideration of outcomes beyond glycaemia. However, Lilly would like to note that the treatment goals listed by the guideline still appear to remain based on glycaemia. Lilly requests that weight	Thank you for your comment. The committee agreed that personalised targets are important for people with type 2 diabetes. The minimally important difference used in the guideline for determining if weight loss was clinically important was 3% (an important level for population wide weight reduction). A weight loss of 10-15% would have proven that all type 2 diabetes therapies in trials were unable to achieve a clinically meaningful level of weight loss when looking at mean

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				targets be considered as equally important as glycaemic targets and be included in the guideline. Omission of weight targets from the guideline Specific weight targets for multiple categories of comorbidities appear to have been omitted from the guideline, and are not currently included for people with type 2 diabetes and obesity, where weight targets are of high importance given the nature of the disease and the prevalence of weight-related comorbidities.²⁻⁶ Similar, specified, weight loss targets for other comorbidities are not included in the rest of the guideline. Weight targets for dietary advice and issues Specific weight targets appear to have been included in the discussion of dietary advice, with weight loss targets of 5–10% set for patients with overweight, however this advice appears to be outdated. There is no timeframe specified to achieve these targets, and these targets appear highly ambitious for diet alone in clinical practice. Results from the first 30 months of the National Health Service Diabetes Prevention Programme, which offered lifestyle advice only, showed the mean weight change of participants to be only –2.7%, and only 24% of participants achieved a reduction of ≥5% of baseline weight.¹⁶ The guideline does not include	weight loss reductions (including tirzepatide). The aim of treatments in this guideline is to primarily provide cardiovascular and renal protection, glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this.

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				recommendations should patients not be able to achieve these targets without pharmacological treatment. Lilly would suggest that if the weight of patients with type 2 diabetes who are given dietary advice only remains unchanged, or if they have not achieved their specific weight target, at three months, then those patients should be escalated to treatment with a more efficacious weight management medication in order to more effectively manage their weight. <i>Evidence supporting weight targets for therapeutic management of type 2 diabetes</i> The American Diabetes Association (ADA) and European Association for the Study of Diabetes (EASD) 2022 Consensus Report highlights the importance of weight loss for outcomes in type 2 diabetes, suggesting that weight loss of 10–15% or more can have a disease-modifying effect and lead to remission of diabetes, and that weight loss may improve risk factors for cardiometabolic disease and quality of life, beyond management of glycaemia alone.⁷ Lilly would suggest that a weight target of a reduction in 10–15% bodyweight be included for people with type 2 diabetes and obesity along with specified timeframes for these to be	

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				achieved, as greater weight loss is needed for the best outcomes for patients.^{17, 18} This target is now achievable with tirzepatide, as shown in SURPASS-2 where 64.9% of patients with type 2 diabetes receiving tirzepatide 15 mg achieved a $\geq 10\%$ weight loss at Week 40,¹¹ and in SURMOUNT-2 where 69.6% of patients with obesity receiving tirzepatide achieved a $\geq 10\%$ weight loss at Week 72.¹⁰ Lilly therefore suggests weight targets be considered as equally important as glycaemic targets and be included in the guideline across all categories (other than heart failure, where weight management is already specified) along with recommended timeframes to achieve these. In addition to this, highly efficacious weight management medications should be considered first-line in the treatment pathway in order to more effectively manage these weight targets for people living with type 2 diabetes and obesity.¹	
Eli Lilly & Company Ltd	Guideline	General		Management of people living with type 2 diabetes and overweight Although Lilly welcomes the categorisation of comorbidities in the treatment pathway, there is no category in the guideline or recommendations for the treatment of people with type 2 diabetes living	Thank you for your comment. The guideline has been designed to take into account the holistic management of type 2 diabetes as a condition. Options are provided for people with type 2 diabetes and their healthcare professionals to give the opportunity to consider comorbidities to manage when

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				with overweight. Lilly requests that a column be added to the treatment algorithm for people with type 2 diabetes and overweight. Current management of overweight in the guideline and issues The guideline currently recommends dietary advice for patients with type 2 diabetes and overweight, along with weight loss targets of 5–10%, however the guideline does not specify therapeutic treatment options for this category. As the definition of overweight is different from obesity, these people would appear to fall into the 'no additional comorbidities' category of the pathway, where the treatment pathway proposed in the draft guidance would therefore be suboptimal due to the patient's weight and increased likelihood of presenting with comorbidities. None of the proposed treatment options after SGLT2is in the 'no additional comorbidities' algorithm support weight loss; conversely, some are known to cause weight gain. A treatment pathway for people living with type 2 diabetes and overweight Lilly believes that the current treatment pathway for obesity is a suitable treatment algorithm for patients with type 2 diabetes and overweight, however would propose that weight targets of a reduction in	considering treatment, this allows flexibility to ensure people who need access to specific treatment can access it. In terms of GLP-1 receptor agonists and tirzepatide, these were not cost effective for people living with overweight. Therefore, it was not recommended for this group. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this.

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				10–15% bodyweight be included along with a specified timeframe to achieve them.¹⁷ The American Diabetes Association (ADA) and European Association for the Study of Diabetes (EASD) 2022 Consensus Report highlights the importance of weight loss for outcomes in type 2 diabetes, suggesting that weight loss of 10–15% or more can have a disease-modifying effect and lead to remission of diabetes, and that weight loss may improve risk factors for cardiometabolic disease and quality of life, beyond management of glycaemia alone.⁷ Lilly would suggest that the current treatment pathway for patients with type 2 diabetes and obesity be replicated, starting with first line treatment using metformin plus a sodium-glucose cotransporter 2 inhibitor followed by a review of glycaemic and weight targets after 3 months of treatment. If their glycaemic targets are not met and/or the patient is not on track to meet their weight targets at 3 months, a more efficacious weight management medication would be offered to better manage their weight. Lilly requests that a new treatment pathway be added to the guideline that includes tailored treatment considerations, as a new column in the algorithm, for people with type 2 diabetes and overweight who are inadequately controlled	

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				in terms of their glycaemic and/or weight loss targets.	
Eli Lilly & Company Ltd	Guideline	020	012	Management of people living with type 2 diabetes and obesity Lilly welcomes the recommendation of more effective therapies (metformin plus a sodium-glucose cotransporter 2 inhibitor [SGLT2i]) earlier in the treatment pathway for people living with type 2 diabetes and obesity, however, there are concerns regarding the use of these therapies as the first-line treatment in clinical practice in the UK when effective treatment options such as glucagon-like peptide-1 receptor agonists (GLP-1 RAs) and tirzepatide are available, which offer significant benefits in glycaemic control and weight loss efficacy. Lilly requests that more efficacious weight management medications be considered as first-line treatment options for people with type 2 diabetes and obesity, ahead of other treatment options Weight targets for people with type 2 diabetes and obesity The American Diabetes Association (ADA) and European Association for the Study of Diabetes (EASD) 2022 Consensus Report highlights the importance of weight loss for outcomes in type 2 diabetes, suggesting that weight loss of 10–15% or more can have a disease-modifying effect and lead	Thank you for your comments. Management of people living with type 2 diabetes and obesity The committee reviewed the clinical and cost-effectiveness of GLP-1 receptor agonists and tirzepatide and agreed that, with the evidence available, while they showed clinical effectiveness in cardiovascular and renal protection (for GLP-1 receptor agonists only) and glycaemic and weight reduction (for GLP-1 receptor agonists and tirzepatide,), that they were not cost effective as initial therapy for people with type 2 diabetes. They agreed that they have a place in therapy as subsequent therapy. The recommendation has been adjusted so that the wording is “GLP-1 receptor agonist or tirzepatide” to acknowledge the place where tirzepatide could be considered for its glycaemic and weight reducing properties. Weight targets for people with type 2 diabetes and obesity The committee agree that personalised targets are important for people with type 2 diabetes. The minimally important difference used in the guideline for determining if weight loss was clinically important was 3% (an important level for population wide weight reduction). A weight loss of 10-15% would have proven that all type 2 diabetes therapies in trials were unable to achieve a clinically meaningful level of weight

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				to remission of diabetes, and that weight loss may improve risk factors for cardiometabolic disease and quality of life, beyond management of glycaemia alone.⁷ The committee states 'Given the limitations of the evidence for people living with obesity, the committee recommended the same medicines for this group as for other people with type 2 diabetes and no other specific comorbidities.'. However, the recommendation of metformin plus an SGLT2i is unlikely to achieve the level of weight loss that would be clinically meaningful (10–15% reduction).¹⁰ <i>Evidence for tirzepatide in the management of type 2 diabetes and obesity</i> The committee have developed their recommendations for the use of semaglutide as a first line treatment option in type 2 diabetes patients with cardiovascular disease based on the strong evidence base for semaglutide in cardiovascular disease.¹⁹ In a similar manner, the use of tirzepatide in people living with type 2 diabetes and obesity has a strong evidence base in weight management within the SURPASS and SURMOUNT trial programmes.¹⁰ The SURPASS-2 trial presents strong clinical evidence for the efficacy and safety of tirzepatide 5 mg, 10 mg and 15 mg in comparison with	loss when looking at mean weight loss reductions (including tirzepatide). The aim of treatments in this guideline is to primarily provide cardiovascular and renal protection, glycaemic benefits and then also weight management benefits as an additional benefit. If weight management is the primary aim then we recommend that guidance is sought from NICE's guideline on overweight and obesity management. Evidence for tirzepatide in the management of type 2 diabetes and obesity Trial data from SURPASS-2 and SURMOUNT were included in the guideline. As stated, tirzepatide showed clinically important reductions in HbA1c and weight change outcomes. We have not received sufficient evidence to state that it has shown evidence of cardiovascular and renal protection. Given this, it should not be recommended ahead of therapies that do have benefits in cardiovascular and renal protection and have been shown to be cost effective for this reason and should be in line with the other GLP-1 receptor agonists. The recommendation for second line therapy has been adjusted so that the wording is "GLP-1 receptor agonist or tirzepatide" to acknowledge the place where tirzepatide could be considered for its glycaemic and weight reducing properties in line with how it was approached in TA924.

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				subcutaneous semaglutide 1.0 mg in patients with type 2 diabetes who had inadequate glycaemic control with metformin monotherapy, demonstrating superior glycated haemoglobin (HbA1c) and body weight reduction at 40 weeks.¹¹ In SURPASS-2, significantly higher proportions of patients on all three doses of tirzepatide (5 mg, 10 mg and 15 mg) achieved mean body weight reductions of $\geq 5\%$, $\geq 10\%$, or $\geq 15\%$ from baseline to 40 weeks compared to semaglutide 1 mg. The proportion of patients on tirzepatide 10 mg and 15 mg achieving $\geq 10\%$ and $\geq 15\%$ body weight reductions at Week 40 was over twice that for semaglutide 1 mg: 35.8%, 52.9%, and 64.9% of patients achieved a body weight reduction of $\geq 10\%$ at 40 weeks for tirzepatide 5 mg, 10 mg and 15 mg respectively, compared to 25.3% achieving this target for semaglutide 1 mg 15.2%, 27.7%, and 39.9% of patients achieved a body weight reduction of $\geq 15\%$ at 40 weeks for tirzepatide 5 mg, 10 mg and 15 mg respectively, compared to 8.7% achieving this target for semaglutide 1 mg The SURMOUNT-2 trial also offers strong clinical evidence for the management of weight reduction in	

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				patients with obesity and type 2 diabetes.¹⁰ SURMOUNT-2 was a 72-week, phase 3, international, multicentre, double-blind, randomised, placebo-controlled trial that investigated the safety and efficacy of tirzepatide 10 mg and 15 mg compared with placebo, all adjunct to a reduced calorie diet and increased physical activity, in participants with overweight or obesity and type 2 diabetes.¹⁰ In SURMOUNT-2, tirzepatide 10 mg and 15 mg each achieved superiority compared with placebo for mean percent body weight reduction from baseline to 72 weeks, with tirzepatide 10 mg and 15 mg showing a 13.4% and 15.7% reduction in body weight from baseline at 72 weeks, respectively.¹⁰ Additionally, tirzepatide 10 and 15 mg each achieved superiority compared with placebo for the percentage of participants achieving $\geq 10\%$, $\geq 15\%$, and $\geq 20\%$ body weight reduction from baseline to 72 weeks: 63.4% and 69.6% of patients achieved a body weight reduction of $\geq 10\%$ at 72 weeks for tirzepatide 10 mg and 15 mg respectively, compared to 8.7% achieving this target for placebo 41.4% and 51.8% of patients achieved a body weight reduction of $\geq 15\%$ at 72 weeks	

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				for tirzepatide 10 mg and 15 mg respectively, compared to 2.6% achieving this target for placebo 23.0% and 34.0% of patients achieved a body weight reduction of $\geq 20\%$ at 72 weeks for tirzepatide 10 mg and 15 mg respectively, compared to 1.0% achieving this target for placebo Tirzepatide has proven efficacy, and a robust evidence base in type 2 diabetes and weight management and has demonstrated superiority to alternative therapies in the reduction of HbA1c and body weight, such as SGLT2is and GLP-1 RAs. Additionally, tirzepatide was considered as a more cost-effective treatment option than GLP-1 RAs, as recommended in TA924. Lilly would propose that more efficacious weight management medications be considered as first-line treatment options for people with type 2 diabetes and obesity, ahead of other treatment options.	
Eli Lilly & Company Ltd	Guideline	027	001	Management of people with type 2 diabetes and heart failure Lilly is in agreement with the first-line treatment recommendations (metformin plus a sodium-glucose cotransporter 2 inhibitor) for the management of heart failure in patients with type 2	Thank you for your comments. We acknowledge the limited evidence for people with type 2 diabetes and heart failure. The health economic modelling showed that subcutaneous semaglutide was the most cost-effective treatment in this population. The committee considered the gaps in the evidence when considering their recommendations and that

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				diabetes. The guideline then states that if further treatment is needed to reach weight management targets (which are unspecified), then 'consider adding subcutaneous semaglutide' if the person is living with obesity, there are no concerns about frailty, and they have a preserved ejection fraction. Lilly requests that subcutaneous semaglutide not be recommended in patients with type 2 diabetes and heart failure due to the lack of evidence for semaglutide 1.0 mg in this population. Lack of evidence for semaglutide 1.0 mg in the management of type 2 diabetes and heart failure Lilly would like to highlight that NICE have not presented data for semaglutide 1.0 mg, which is the licensed dose for the management of type 2 diabetes in the UK and available on the NHS, as the evidence base for their recommendation of semaglutide in the treatment of heart failure in people with type 2 diabetes. Specific doses are not recommended by NICE in the treatment pathway; therefore, it is unclear which doses are included within the recommendations. It is therefore not clear as to whether NICE are recommending the semaglutide 1.0 mg dose in patients with type 2 diabetes and heart failure, despite there being no available evidence for semaglutide 1.0 mg in this population.	inputs for the heart failure population largely borrowed from other populations or were inputted as 1 (equal to metformin) where evidence was not identified for this population. Given these uncertainties a weaker consider recommendations was made. When considering the clinical evidence, the committee agreed that the findings could be applied but agreed that the findings are limited and there is still uncertainty. Given this they made a weaker consider recommendation. Regarding the SUMMIT trial, this discusses tirzepatide for people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update. Regarding the STEP-HFpEF, this study was included as the review protocol specified that any dose of semaglutide would be included in the review. We agree that the dose is outside of the licensed dose for people with type 2 diabetes. Given this and the limited evidence for people with heart failure, we have removed the consider recommendation for semaglutide in this population. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare

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				<i>Evidence for tirzepatide in the management of type 2 diabetes and heart failure</i> The SUMMIT trial showed the benefit of tirzepatide (maximum titrated dose 5 mg, 10 mg or 15 mg once weekly) in adults with heart failure with preserved ejection fraction and obesity. In the trial, 48% of patients had type 2 diabetes, and all doses that were used in the trial are licensed for the treatment of type 2 diabetes in the UK. In SUMMIT, tirzepatide reduced the risk of heart failure outcomes – heart failure urgent visit or hospitalisation, oral diuretic intensification or cardiovascular death – by 38% compared to placebo, and at 52 weeks significantly improved heart failure symptoms and physical limitations. Tirzepatide led to 11.6% weight loss in a combined population of people with and without type 2 diabetes at 52 weeks.¹³ As of 24th September 2025, data for tirzepatide in patients with HFpEF and obesity from the SUMMIT trial have been included in 'Section 5.1: Pharmacodynamic properties' of the tirzepatide summary of product characteristics.⁸ <i>Issues with evidence for semaglutide in the management of type 2 diabetes and heart failure</i> The reasoning that the committee gives for the recommendation of subcutaneous semaglutide is	professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.

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				that there was 'limited, very low-quality evidence' available in people with type 2 diabetes and heart failure, noting that this came from a small single study. The referenced study, STEP-HFpEF, explored the use of subcutaneous semaglutide 2.4 mg in patients with heart failure with preserved ejection fraction and obesity.¹⁴ Lilly notes that subcutaneous semaglutide 2.4 mg is not a licensed dose for the treatment of type 2 diabetes in the UK, but instead is licensed for the treatment of obesity, and semaglutide 2.4 mg therefore is not available to prescribers in NHS primary care. Additionally, the recently published STEP-HFpEF DM study mentioned by the committee also explores the same, differently licensed 2.4 mg dose.²¹ In comparison, the evidence presented for subcutaneous semaglutide for the treatment of cardiovascular disease from the SUSTAIN-6 trial uses the 1.0 mg dose which is licensed for the treatment of type 2 diabetes in the UK.¹⁹ It is important to make clear in the guideline the difference in semaglutide dosages used for the evidence supporting the different comorbidities, due to both the different licensing of the semaglutide 2.4 mg dose, and because NICE has only recommended the semaglutide 2.4 mg dose for the treatment of obesity in specialist weight	

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				management services, therefore it will not be available in primary care.¹⁵ Additionally, the UKPDS Outcomes Model 2 that provided the economic evidence to support the development of the guidelines does not appear to have used the cost of the semaglutide 2.4 mg dose, which is considerably higher than the cost of semaglutide 1.0 mg, and the confidential patient access scheme offered for semaglutide 2.4 mg is only available in specialist weight management services, therefore the cost-effectiveness results are highly likely to be incorrect when taking heart failure into consideration. As no evidence has been presented for semaglutide 1.0 mg in type 2 diabetes and heart failure, and as semaglutide 2.4 mg is not licenced for the treatment of type 2 diabetes in the UK, Lilly would strongly suggest that semaglutide not be included in the recommendation for patients with type 2 diabetes and heart failure.	
Eli Lilly & Company Ltd	Guideline	028	001	Management of people with type 2 diabetes and atherosclerotic cardiovascular disease The recommendation of more effective treatment options for the first-line management of cardiovascular disease in people with type 2 diabetes, namely the recommendation of metformin plus a sodium-glucose cotransporter 2 inhibitor	Thank you for your comment. The committee considered this. While we have seen the initial findings from the SURPASS CVOT trial, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review. The SUSTAIN-6 trial includes a mixed population of people with CVD, heart failure and CKD. As a consequence, the data from this trial were not included in the analysis for people with

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				(SGLT2i) plus semaglutide, is a positive step forward in offering the most effective treatment options for patients earlier. Lilly acknowledges that although treatment with semaglutide was shown to be cost effective, clinical advisors have suggested that in practice, clinicians will rarely prescribe a triple therapy at first line due to tolerability concerns. It should be made clear within the treatment algorithm, which is likely to be the first reference point for busy HCPs, that patients be started on the most effective therapy first, with addition of less effective components of the triple therapy following on sequentially as required, as this is not immediately clear from the pathway figure. <i>Evidence for tirzepatide in the management of type 2 diabetes and ASCVD</i> The committee noted that semaglutide was recommended over other glucagon-like peptide-1 receptor agonists for the treatment of patients with type 2 diabetes and atherosclerotic cardiovascular disease (ASCVD) based on the availability of evidence presented and cost-effectiveness. In order to compare tirzepatide to semaglutide in this population, tirzepatide would need to be indirectly compared using data from the SURPASS-CVOT trial, which explores the benefit of tirzepatide on cardiovascular outcomes versus dulaglutide, to	atherosclerotic cardiovascular disease. As stated in this comment, the REWIND trial includes people with and without atherosclerotic cardiovascular disease and therefore, would not be appropriate to use to determine a putative placebo from that we could use to compare against in relation to the methods in the review used for this guideline, where the two trials would be in different population strata and so should not be combined in a network meta-analysis. When considering this against the network meta-analyses included in this guideline, there is one outcome (3-item MACE) where a connection could be made into an existing network meta-analysis. This outcome does not factor into the economic modelling. We did not receive enough information about the baseline characteristics and methods of the study to verify that this is appropriate to do. Overall, as we could not assess the SURPASS-CVOT trial and the other trials were not eligible for inclusion, we did not receive sufficient evidence to support assessment of the clinical effectiveness of tirzepatide. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection while GLP-1 receptor agonists included in the review have shown this and subcutaneous semaglutide has also shown cost-effectiveness, therefore has been recommended. Tirzepatide has been considered for other populations in line with the current evidence included in TA924.

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				subcutaneous semaglutide 1.0 mg using the SUSTAIN-6 trial, via the dulaglutide 1.5 mg arm from the REWIND trial.^{12, 19, 20} Even though the populations of the SURPASS-CVOT and SUSTAIN-6 trials are generally aligned, there are important differences in patient populations in the connecting comparison between tirzepatide and dulaglutide, primarily being that REWIND included a broader range of risk populations, while SURPASS-CVOT enrolled only patients with established cardiovascular disease, and differing glycated haemoglobin (HbA1c) inclusion criteria (SURPASS-CVOT: HbA1c 7–10.5%; REWIND: HbA1c ≤9.5%).^{12, 20} Similar differences in populations would be observed between the REWIND and SUSTAIN-6 trials. This would mean that any results of an indirect comparison in the NMA via dulaglutide would be considered as conservative. SURPASS-CVOT: Primary and secondary endpoints At the time of development of the guideline draft, data from the SURPASS-CVOT trial were not available, however Lilly has recently published results from the trial. Results from the SURPASS-CVOT have been provided in the reference pack alongside the response document, with key information presented below.¹²	Any relevant studies such as the SURPASS-CVOT trial published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline

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				In SURPASS-CVOT, which compared the maximum titrated dose (MTD) of tirzepatide with dulaglutide 1.5 mg, treatment with tirzepatide MTD met the pre-specified criteria for non-inferiority compared with dulaglutide on the rate of the primary composite MACE-3 (cardiovascular [CV] death, myocardial infarction or stroke) endpoint. Primary and key secondary results from SURPASS-CVOT are as follows:¹² Primary endpoint: - MACE-3: - Hazard ratio (HR): 0.92 (confidence interval [CI]: 0.83–1.01), p=0.003 (non-inferiority, 1-sided), p=0.086 (superiority, 2-sided) Secondary endpoints: - MI: - HR: 0.86 (CI: 0.74–1.00) - Stroke: - HR: 0.91 (CI: 0.76–1.09) - CV death: - HR: 0.89 (CI: 0.77–1.02) - MACE-4 (CV death, myocardial infarction, stroke or coronary revascularisation): - HR: 0.88 (CI: 0.81–0.96)	

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				- CV death or hospitalisation or urgent visits for HF: - HR: 0.91 (CI: 0.81–1.03) - All-cause death: - HR: 0.84 (CI: 0.75–0.94) <i>SURPASS-CVOT: Indirect estimate of tirzepatide versus putative placebo</i> The analysis of tirzepatide in comparison to putative placebo was pre-specified in the SURPASS-CVOT statistical analysis plan. Despite the aforementioned differences between the SURPASS-CVOT and REWIND populations, similar event rates were observed in the dulaglutide 1.5 mg arms following matching of the REWIND population to the SURPASS-CVOT based on SURPASS-CVOT eligibility.¹² A pre-specified indirect comparison analysis of matched patient-level data from the REWIND and SURPASS-CVOT studies found that tirzepatide reduced the risk of MACE-3 (HR: 0.72; 95.0% CI: 0.55 to 0.94) and all-cause mortality (HR: 0.61; 95.0% CI: 0.45 to 0.82) compared to a putative placebo.¹² Further results from the adjusted indirect estimate of tirzepatide MTD (SURPASS-CVOT) vs placebo (REWIND, adjusted) are as follows, presented alongside the results of dulaglutide 1.5 mg vs	

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				placebo (REWIND, adjusted). Detailed outcomes have been provided in the reference pack alongside the response document:¹² • MACE-3: ○ Dulaglutide 1.5 mg vs placebo: HR: 0.78 (CI: 0.61–1.01), p=0.06 ○ Tirzepatide MTD vs placebo: HR: 0.72 (CI: 0.55–0.94), p=0.02 • MACE-4: ○ Dulaglutide 1.5 mg vs placebo: HR: 0.91 (CI: 0.73–1.12), p=0.37 ○ Tirzepatide MTD vs placebo: HR: 0.80 (CI: 0.64–1.01), p=0.006 • CV death: ○ Dulaglutide 1.5 mg vs placebo: HR: 0.85 (CI: 0.60–1.20), p=0.35 ○ Tirzepatide MTD vs placebo: HR: 0.75 (CI: 0.52–1.09), p=0.13 • All-cause death: ○ Dulaglutide 1.5 mg vs placebo: HR: 0.73 (CI: 0.55–0.96), p=0.03 ○ Tirzepatide MTD vs placebo: HR: 0.61 (CI: 0.45–0.82), p=0.001 • CV death or HF events ○ Dulaglutide 1.5 mg vs placebo: HR: 0.77 (CI: 0.58–1.03), p=0.08	

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				○ Tirzepatide MTD vs placebo: HR: 0.70 (CI: 0.51–0.96), p=0.03 Overall, SURPASS-CVOT demonstrated that tirzepatide is cardioprotective in participants with established ASCVD and type 2 diabetes. Additionally, SURPASS-CVOT has shown promising results in renal outcomes for patients with type 2 diabetes and CVD, within the subpopulation of patients with high-risk chronic kidney disease (N=2,923), slowing the decline in kidney function, reducing the progression of albuminuria, and reducing the risk of major kidney events.	
Hywel Dda University Health Board	Guideline	General		Steatotic liver disease is a common comorbidity with type 2 diabetes, it would be helpful to have guidance on medication choice in this situation.	Thank you for your comment. As part of the reviewing process, subgroup analyses were planned for populations with and without non-alcoholic fatty liver disease, however, the evidence did not provide data for these subgroups and so the committee were unable to make separate recommendations for this population. There is a guideline update (NG49) and two ongoing technology appraisals in this area: 1. Resmetirom for treating non-alcoholic steatohepatitis and liver fibrosis 2. Semaglutide for treating metabolic dysfunction-associated steatohepatitis with liver fibrosis
Hywel Dda University Health Board	Guideline	General		Evidence in relation to cardiovascular benefits of GLP1 is constantly evolving, would the guidance be potentially future-proofed if instead of	Thank you for your comment. The committee agreed that recommendations should be made using the current evidence for treatment that is most effective for giving people the

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				recommending "subcutaneous semaglutide" it recommended "a GLP1 with proven cardiovascular benefits"?	benefits that they need. Therefore, they made a recommendation for treatment that is clinically and cost effective at this current time, which was subcutaneous semaglutide. This is an area where surveillance work is underway and as new evidence is identified this will be added and adjustments will be made.
Hywel Dda University Health Board	Guideline	015	029	We agree with the importance of highlighting the impact of language.	Thank you for your comment.
Hywel Dda University Health Board	Guideline	018	004	Offering an SGLT-2 inhibitor to all will significantly alter practice. If the number of appointments is not increased, the duration of the appointments will need to be increased in order to appropriately cover all the discussion and counselling points needed. There will also be a significant impact on prescribing budgets. In our clinical experience we have observed that starting an SGLT2i in a person with a very high initial HbA1c leads to a much higher rate of adverse effects, which can lead to discontinuation of treatment. In practice, we will often use another therapy short-term in this cohort in order to lower the glucose levels before initiating the SGLT2i. We feel that this facilitates better tolerance of the drug, enabling more people to continue treatment and access the long term benefits. Would the committee	Thank you for your comment. We acknowledge that this will lead to increased costs. However, we also note that this will lead to benefits in reducing the number of cardiovascular events (including deaths, myocardial infarctions and non-fatal strokes) long-term which will in turn reduce the amount of time required for service use and improve people's lives. The committee considered adding advice about SGLT-2 and people with high baseline glucose levels. They ultimately agreed that the concern in this scenario is more about managing the causes of the adverse events, such as dehydration and volume depletion, that can increase the risk of events such as diabetic ketoacidosis. Given this then updated the recommendations in the section about "Preventing diabetic ketoacidosis when taking SGLT-2 inhibitors" to give warning about this. They acknowledged that while a high baseline HbA1c can be a concern for starting an SGLT-2 inhibitor, it was not an absolute contraindication, and each case should be considered on a case by case basis.

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				consider adding advice on cautious introduction in people with initially high blood glucose?	
Hywel Dda University Health Board	Guideline	020	011	In the rationale for people with atherosclerotic CVD, it states that subcutaneous semaglutide is more clinically effective and more cost-effective, why does this recommendation not also recommend it in preference to other GLP1 here? It is being used for cardiovascular risk reduction.	Thank you for your comment. For those people with atherosclerotic cardiovascular disease and type 2 diabetes, out of the GLP-1 receptor agonists and tirzepatide only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits. However, as noted in the committee discussion and rationale, no treatments are cost effective for people with early-onset type 2 diabetes. Due to this, recommending one GLP-1 receptor agonist or tirzepatide over another would not be appropriate. Therefore, the committee made a class-level recommendation in this population. We did not find any specific evidence for adults 18 to 25 years that met our review protocol. The committee identified this as a gap in the evidence and therefore made a research recommendation around treatments for people with early-onset type 2 diabetes.
Hywel Dda University Health Board	Guideline	021	012	We acknowledge that only dapagliflozin and empagliflozin are licensed to treat CKD. However, although not specifically licensed to treat CKD, canagliflozin is licensed for treating people with diabetes even when there is reduced renal function. Since the committee discussion paper on page 12 recognises that "Canagliflozin had strong evidence of a clinically important benefit in reducing end-stage renal failure while dapagliflozin had weak evidence of a clinically important benefit", we would	Thank you for your comment. The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .

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				suggest that canagliflozin is included as an option here.	
Hywel Dda University Health Board	Guideline	023	017	We are aware that some people routinely prescribe ketone testing strips to people prescribed SGLT2i for use when they are unwell. This has a significant cost impact. It would be helpful if the committee could clarify whether this is appropriate.	Thank you for your comment. We have not reviewed the evidence for this, so we are unable to comment. We have not produced any recommendations to suggest that this should be done routinely.
Hywel Dda University Health Board	Guideline	025	014	Could the committee provide clarity on what would or wouldn't be considered as "helping to reach targets". This is somewhat vague, bearing in mind that the targets are individualised. Is any progress at all considered "helping" or should there be a particular threshold of benefit? Must someone have reached their targets in order for a medicine to have "helped"?	Thank you for your comment. Wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes. The progress achieved can be determined by working with the person with the condition and coming to an agreement with them.
Hywel Dda University Health Board	Guideline	025	014	We see considerable uncertainty and debate amongst clinicians about continuing medication or stopping when weight and HbA1c reduce so much that a person has a HbA1C which is far below the threshold for diabetes, and weight in healthy BMI range. (i.e. it is likely that the results may remain below target even if the medication was stopped). Potentially the diabetes may be in remission but cannot be categorised as in remission while a person remains on treatment. In these circumstances presumably the risk/benefit of continuing treatment alters. It would be helpful if the committee could provide guidance on this scenario,	Thank you for your comment. The committee agree that this is an area of importance and wanted to find out more about what they could say on this. Remission was an outcome in the guideline, but little evidence was identified for this. We therefore included it in a research recommendation. We have no additional guidance we can provide in this area at this time.

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				or make a recommendation for research if there is currently insufficient evidence to advise.	
Hywel Dda University Health Board	Guideline	025	020	We agree with this recommendation.	Thank you for your comment.
Hywel Dda University Health Board	Guideline	027	005-008	Are these points “and” or “or”?	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
Hywel Dda University Health Board	Guideline	030	016	The TA for the use of tirzepatide no longer correlates with prescribing practice. Following the previous recommendation 1.8.56, people with obesity will be prescribed Metformin plus SGLT2i plus GLP1, plus sulfonylurea or pioglitazone before they met the criteria of “metformin plus two other oral therapies”. Would we then be switching the GLP1 for tirzepatide?	Thank you for your comment. The wording discussing GLP-1 receptor agonists has now been changed to say “GLP-1 receptor agonist and tirzepatide” to show the role of tirzepatide in this population. The recommendation about the technology appraisal for tirzepatide has been removed as this medicine has now been added into the guideline.
Hywel Dda University Health Board	Guideline	031	003	Bearing in mind that CVD is a leading cause of death amongst people with CKD, why was a DPP-4 inhibitor recommended in place of a GLP1 which has CVD benefits? This is not explained in the	Thank you for your comment. The rationale for DPP-4 inhibitors can be read in the rationale and impact section. While the FLOW trial showed clinically important benefits in renal and cardiovascular protection, this did not correspond to

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				discussion and seems at odds with the decision to use GLP1 for people with early onset diabetes due to cardiovascular risk (recommendation 1.8.18).	cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Hywel Dda University Health Board	Guideline	039		Could a definition of GLP1 be included please? Specifically, could you clarify whether Tirzepatide is included in this class, or whether it is considered in a separate class due to being a dual agonist.	Thank you for your comment. "GLP-1 receptor agonists or tirzepatide" has now been added to the recommendations where tirzepatide is included..
Kidney Care UK	General			We would like to see included in the medicines for people with diabetes and chronic kidney disease a recommendation that GLP-1 agonists be prescribed for people in whom obesity poses a barrier to transplantation. This would have important quality of life, clinical and cost-effective benefits. We know from our online support groups (over 14,000 members) that patients struggling with challenges of end stage kidney disease (ESKD) are really interested in the potential for GLP-1 agonists to help them towards a successful transplant. Where finances allow, some people are following the	Thank you for your comment and the important feedback from your members. We have reviewed the evidence for GLP-1 receptor agonists. On checking the clinical evidence, the committee agreed they are clinically effective for people living with obesity with CKD stage 3a with significant albuminuria. However, health economic modelling showed it was not cost-effective. Given this, the committee agreed that there was insufficient evidence to recommend GLP-1 receptor agonists for the indication of chronic kidney disease at this time. However, as stated in the amended recommendations in the section on

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				private prescription route and we are very worried about the resulting exacerbation in inequalities in access to life-changing kidney transplants. It is already the case that people from deprived groups have poorer access to the kidney transplant waiting list. ¹ A positive recommendation for this intervention would be one way of increasing equity of access. Obesity is a risk factor for delayed graft function, primary non-function ² and surgical complications ³ . Therefore, obesity can reduce the chance of being listed for transplantation and weight loss can improve access to successful outcomes in people receiving a kidney transplant. A survey of UK transplant centres found only three had no cut off for BMI, suggesting barriers to transplantation in all others. ² All respondents considered high BMI to adversely affect graft outcomes. An estimated 18.4% of people with ESKD have a BMI of above 35. ² Access to weight loss services are extremely limited and conservative methods for weight loss demonstrate generally poor results and are made	'Involving people in medicine discussions', if a person has more than one comorbidity, a shared decision can be made with them about which comorbidity to prioritise when choosing medicines (in this scenario, this may be relevant for people with chronic kidney disease who are living with obesity).

¹ Pruthi R, Robb ML, Oniscu GC, Tomson C, Bradley A, Forsythe JL, Metcalfe W, Bradley C, Dudley C, Johnson RJ, Watson C, Draper H, Fogarty D, Ramanan R, Roderick PJ; ATTOM Investigators. Inequity in Access to Transplantation in the United Kingdom. Clin J Am Soc Nephrol. 2020 Jun 8;15(6):830-842. doi: 10.2215/CJN.11460919. Epub 2020 May 28. PMID: 32467306; PMCID: PMC7274279.

² Kostakis ID, Kassimatis T, Bianchi V et al. UK renal transplant outcomes in low and high BMI recipients: the need for a national policy. Journal of Nephrology (2020)33:371-381

³ Chen Y, Dabbas W, Gangemi A, Benedetti E, Lash J, Finn PW, Perkins DL. Obesity Management and Chronic Kidney Disease. Semin Nephrol. 2021 Jul;41(4):392-402. doi: 10.1016/j.semnephrol.2021.06.010. PMID: 34715968.

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				more difficult in ESKD patients due to diet restrictions and poor exercise tolerance.² Kidney transplants are the gold standard treatment for kidney failure. It means people can engage in activities they love, potentially restart careers and spend more time with their families. It also prolongs life expectancy compared with long-term dialysis.⁴ As well as benefits to patients, NHS Blood and Transport (NHSBT) report that kidney transplantation, both living and deceased, has the greatest health economic impact of all solid organ transplantation due to savings to the NHS in dialysis costs. Using figures from the Department of Health and Social Care (DHSC) in England in 2015, the estimated cost of a kidney transplant in the first year was £55,288, reducing to £8,526 for follow up. The costs of dialysis at that time were estimated to be £29,841 per year.⁵ These important facts necessitate that people with diabetes and chronic kidney disease who cannot access transplantation due to a high BMI should be a priority group for accessing GLP-1 agonists. In addition to clinical and cost benefits, this would reduce the risk of growing inequalities in access to	

⁴ JAMANetworkOpen.2022;5(10):e2234971.doi:10.1001/jamanetworkopen.2022.34971

⁵ (NHS Blood and Transplant (2021) Organ donation and transplantation 2030: meeting the need. <https://nhsbt.dbe.blob.core.windows.net/umbraco-assets-corp/23463/meeting-the-need-2030.pdf> (accessed June 2024).

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				transplantation based on who can afford to privately purchase this medication.	
Kidney Research UK	Guideline	005	008	Recommendation 1.11.3 mentions 1.11.1 [2006 amended 2022]. We would like chronic kidney disease (CKD) included as a separate point because it is known to be a complication of both diabetes and living with obesity. See: Chronic Kidney Disease: Its Relationship With Obesity - PMC Shows that direct and indirect mechanisms link obesity and CKD. Body composition in chronic kidney disease - PMC Recent studies show a high BMI is not protective for all patients with chronic kidney disease (i.e. obesity is associated with kidney damage) and is associated with poor physical functioning and frailty.	Thank you for your comment. We appreciate your interest in NICE's work. However, recommendations on NICE's guideline on overweight and obesity management [NG246] are out of scope for this update.
Kidney Research UK	Guideline	010	019	Amend bullet to read 'reinforce advice about diet, healthy living and adherence to medicines where appropriate considering factors that may be barriers such as socioeconomic and lifestyle and'	We appreciate your interest in this recommendation. However, the updates made were regarding wording refreshes rather than about changes to the meaning of the recommendation, as the evidence for this was not reviewed and this was out of the scope of the update. Therefore, we are not suggesting changing the meaning of the recommendation at this time.
Kidney Research UK	Guideline	015	010	Thank you for including renal protection.	Thank you for your comment.

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Kidney Research UK	Guideline	016	007	Amend sentence to read 'Give clear sick day rules tailored to each person's individualised treatment plan and health literacy.' There is a need to ensure that individuals with low health literacy understand the risk associated with stopping / not stopping their medication.	Thank you for your comment. We agree that this is important. This is discussed in NICE's guideline about patient experience in the NHS which is cross referenced in this guideline.
Kidney Research UK	Guideline	017	002	After renal status insert urine Albumin-to-Creatinine Ratio (uACR).	Thank you for your comment. NICE recommendations should be implemented by healthcare professionals with appropriate training and experience. It is expected that healthcare professionals using the guidance would be aware of appropriate tests for assessing a person's renal status. The guideline cross refers to the chronic kidney disease guideline where guidance on these tests, including urinary ACR can be checked against
Kidney Research UK	Guideline	018	011	Amend to 'People living with heart failure'.	Thank you for your comment. We appreciate this thought and have checked this with our editorial team. We do not believe that the wording needs to be updated for this section at this time as "people with heart failure" seems to be an accepted term by the community though we are always willing to learn and correct this if we hear differently.
Kidney Research UK	Guideline	021	006	Thank you for including this section.	Thank you for your comment.
Kidney Research UK	Guideline	023	012	Amend to '...and checking tolerability while encouraging adherence'. We recognise that this is a challenge and that patients may be required to attend multiple appointments which may be a burden.	Thank you for your comment. We are now recommending modified release metformin for most people with diabetes which will help to aid adherence. We are not making an explicit statement about checking tolerability while encouraging adherence here as this is discussed in NICE's guideline on shared decision making which is referenced in this guideline

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Kidney Research UK	Guideline	025	010	Thank you for including this line. We recognise the value of this statement.	Thank you for your comment and support of this recommendation.
London School of Hygiene and Tropical Medicine	Health inequalities report	General		In the PERMIT study we also looked at whether there were inequalities in uptake of SGLTi by ethnicity and deprivation. We found that when we examined absolute (not relative) differences in the percentages who had SGLTis vs other second-line differences there were not inequalities by ethnicity or deprivation Among people with T2DM, there were no substantial differences by ethnicity or deprivation level in the percentage prescribed either SGLT2 inhibitors, DPP-4 inhibitors or SUs as second-line antidiabetic treatment (Bidulka et al. 2023). Bidulka P, Mathur R, Lugo-Palacios DG, O'Neill S, Basu A, Silverwood R, Briggs A, Adler AI, Douglas IJ, Khunti K, and Grieve R+. Ethnic and socioeconomic disparities in initiation of second-line antidiabetic treatment in people with type 2 diabetes in England: a cross-sectional study. Diabetes, obesity & metabolism vol. 25,1 (2023): 282-292. doi:10.1111/dom.14874	Thank you for your comment. The findings you have highlighted are certainly interesting and add useful context to the discussion. It is worth noting, however, that the data you refer to relates to a different population from the one examined in our health inequalities report, which may explain some of the differences in outcomes
London School of Hygiene and Tropical Medicine	Committee Discussion	016	045	1.5.7.2 SGLT-2 inhibitors It is stated that: 'There was conflicting data for all-cause mortality, with dapagliflozin showing a clinically important	Thank you for your comment and for providing your fascinating study results., We appreciate the findings. The main conclusions for the recommendations were not based on all-

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				benefit and canagliflozin and empagliflozin showing a clinically important harm when compared to placebo. However, the evidence of benefit was low quality and evidence of harm was very low quality. There was no evidence of clinically important change in BMI for the SGLT-2 inhibitors.' We are concerned that the committee did not consider evidence from an NIHR funded study (PERMIT). Although this study was non-randomised it did use strong NICE recommended methods for the design and analysis (target trial emulation) to directly compare SGLTis with relevant comparators (DPP4is and Sulfonylureas) at second line for people with T2DM treated in the NHS. We found no difference in all cause death over two years between the treatment groups (Bidulka et al. 2024). Bidulka P, Lugo-Palacios DG, Carroll O, et al. Comparative effectiveness of second line oral antidiabetic treatments among people with type 2 diabetes mellitus: emulation of a target trial using routinely collected health data. BMJ. 2024 https://www.bmj.com/content/385/bmj-2023-077097	cause mortality, but it is reassuring to know that our findings align. Unfortunately, the PERMIT study had a cohort study design; therefore was not eligible for inclusion in the evidence review as the protocol stated that only randomised controlled trials were to be included. This is because we always aim to include the highest quality study design as evidence, of which RCTs are the gold standard for intervention reviews. In this case we had a particularly large amount of randomised evidence and so did not search for studies outside of this.
Medtronic	Scope	002	Section 3.1	<i>The scope for this update outlines groups that will be covered.</i> <i>We ask the committee to consider the addition of a further subgroup, for people with Severe Insulin-</i>	Thank you for your comment. When the scope was developed, it went through stakeholder consultation and a final version

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				Deficient Diabetes (SIDD), within the “early onset type 2 diabetes (diagnosed before 40 years of age)” group. SIDD is particularly prevalent in this young T2DM population, characterised by early onset, low BMI, low C-peptide, absence of autoantibodies, and a high risk of microvascular complications. In SIDD, glycaemic variability is high and both GLP-1 receptor agonists and insulin therapy may fail to achieve glycaemic targets, leaving patients exposed to ongoing risk of complications. The clinical profile closely resembles Type 1 diabetes and SIDD should be considered as a distinct sub-group Despite having a similar pathophysiology to those with Type 1 diabetes, people with SIDD do not routinely receive access to diabetes technologies such as continuous glucose monitoring (CGM) or hybrid closed loop (HCL) systems that are available to those with T1DM. We ask the committee to consider that access to technology is essential to ensure comparable outcomes for SIDD patients and to consider this inequality of access in their equality considerations. We ask the committee to consider that NHS annual costs for T1DM escalate dramatically with microvascular complications and early and effective	was published in February 2023. Therefore, it is not possible to add further groups at this stage. We will pass the information you have provided to the surveillance team at NICE so that it can be considered in any future updates.

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				<i>glycaemic control with diabetes technologies can prevent these costly complications, offering high return on investment and improved patient outcomes.</i> 1. <i>Denni JM, Shields WE, et al. Disease progression and treatment response in data-driven subgroups of type 2 diabetes compared with models based on simple clinical features: an analysis using clinical trial data Lancet Diabetes Endocrinol. 2019 Jun;7(6):442-451. doi: 10.1016/S2213-8587(19)30087-7. Epub 2019 Apr 29.</i>	
Menarini Diagnostics Ltd	Guideline	012	021	Would extension to the current guidance to include individuals requiring MDI insulin therapy without further requirements be considered to align with other countries indications for wider access to CGM? Alternatively, those on basal insulin treatment to allow more people to benefit from the technology. When is this being reviewed?	Thank you for your comment. This section is out of scope for the guideline update.
Menarini Diagnostics Ltd	Guideline	012	022	Is it prudent to reflect the current landscape of CGM available in the UK to remove references to isCGM or flash monitoring. To align with current options which are considered real time CGM with the terminology used within the guidance.	Thank you for your comment. This section is out of scope for the guideline update.
NHS Bath and North East	Guideline	General	General	Generally, our ICB fully agree with the PresQIPP response to this consultation	Thank you for your comment and for reviewing the guideline. Please see the responses to the PresQIPP comments for further information about our responses.

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Somerset, Swindon and Wiltshire ICB					
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	Guideline	General	General	Clarity is needed throughout the guidance on the use of the term 'GLP1'. Tirzepatide is a dual incretin agonist and it needs to be very clear in the guideline that 'GLP1' does not mean tirzepatide. In some cases, it also needs to be very specific about which drug name should be used, e.g. there is generic liraglutide available now & for some cohorts that might be the most appropriate /more cost-effective option to use.	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist or tirzepatide" to show the role of tirzepatide in this population. We have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Bath and North East	Guideline	General	General	The guidance should clearly state that generic SGLT-2 inhibitor formulations only should be used,	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day

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Somerset, Swindon and Wiltshire ICB				which are far more cost-effective than the brands that haven't lost their patent.	to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	Visual summary			Most patients being treated for T2DM will have multiple co-morbidities. For clinicians in a busy clinic, it would be useful to have some kind of commentary about how you choose what to treat someone with if they have e.g. obesity, CKD & HF? Also, the summary should state that generic SGLT2s should be used. In the obesity arm of the flowchart, should it state tirzepatide as a GLP1/GIP or do you mean they should use semaglutide or	Thank you for your comment. Extra information has been added to the recommendation about factors to consider when the person with diabetes and the healthcare professional are considering how to prioritise treatment. We have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages,

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				liraglutide where you say "GLP1"? Should the GLP1 in the early onset part state generic liraglutide as the most cost-effective option for that cohort with low CV risk?	price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin). The wording has changed to "GLP-1 receptor agonists or tirzepatide" to reflect where tirzepatide is placed in the pathway.
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	Guideline	018	004	Is it reasonable and cost effective to start all patients with T2D and a low risk of cardiovascular disease on an SGLT-2 inhibitor?	Thank you for your comment. We have added to the rationale. The committee agree that no person with type 2 diabetes is truly at low risk of cardiovascular disease (some may be at lower risk relative to others, but all have a high level of lifetime risk of developing cardiovascular disease). They also agree that a population wide recommendation is important for reduce inequities in care. By making a population-wide recommendation, we hope that this will reduce inequities in care by driving forward access for everyone. We acknowledge the increased risk of side effects. However, we believe that the

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					reduction in risk of developing cardiovascular disease may be worthwhile balancing the lower likelihood of severe adverse events for most people. For example: the risk of dying from cardiovascular causes from diabetes in 61 in 1000 according to our review, taking an SGLT-2 inhibitor can reduce this by 3 to 22 in 1000 over 3 years, while the risk of Fournier's gangrene and diabetic ketoacidosis is between 1 in 1000 and 1 in 10,000 according to the BNF. This should be balanced against the risk of less severe genitourinary infections which occurs in around 10 in 1000 to 100 in 1000. The committee agreed that providing that option to people with type 2 diabetes is clinically and cost-effective and we believe that supporting people with diabetes to decide if this is best for them will lead to better outcomes long term.
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	Guideline	020	005	It seems illogical that a person with early onset T2D (who is very likely to be living with obesity) may be considered for a GLP-1 agonist, yet a person with T2D living with obesity (without early onset) will not be. The potential conflict with the eligibility criteria for GLP-1 agonists for weight loss only is understandable, but makes this guidance inconsistent.	Thank you for your comment. We appreciate that this is an area of where the two groups have differences. People with early onset type 2 diabetes have a higher lifetime risk of developing cardiovascular and renal disease than people with later onset type 2 diabetes. While they may or may not also be living with obesity, the benefits from a GLP-1 receptor agonist are primarily to provide heightened cardiovascular and renal protection in this case. This is explained in the rationale and committee discussion document. Treatments in the type 2 diabetes guideline focus on management of cardiovascular and renal protection and glycaemia management. Weight reduction may be a beneficial side effect of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. If the primary aim of

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					treatments is for weight management, please see the overweight and obesity management guideline. Edits have been made to the guideline to reinforce this.
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	Guideline	030	016	TA924 does not align with this pathway for people with T2D living with obesity. TA924 states tirzepatide is an option if 'triple therapy with metformin and 2 other oral antidiabetic drugs is ineffective, not tolerated or contraindicated'. On this pathway the person will be unlikely to have triple oral therapy - they will be on metformin, SGLT-2i and a GLP-1. Either this guideline pathway or TA924 needs amending so that they align.	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist and tirzepatide" to show the role of tirzepatide in this population. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the tirzepatide technology appraisal.(TA924).
NHS Birmingham and Solihull ICB	Guideline			If eGFR < 45 ml/min/1.73m ² then the SGLT2 will have limited glycaemic benefit. Patients will probably require DPP4 or insulin adding in to maintain glycaemic control as SGLT2i will be for reducing worsening of renal function. SGLT2 won't be enough if used as monotherapy for patients with eGFR < 45 and metformin intolerance.	Thank you for your comment. We agree with you. The committee was also in agreement that the purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Evidence identified in the evidence review and the technology appraisals for dapagliflozin and empagliflozin for chronic kidney disease which were used to support their recommendations for people with an eGFR between 20 ml/min/1.73m² and 30 ml/min/1.73m² showed that HbA1c reductions were shown for people with HbA1c values less than 45 ml/min/1.73m². We acknowledge that these benefits may be reduced, though there are still likely to be benefits in prescribing it. However, we agree that HbA1c reductions may not be achieved by SGLT-2 inhibitors alone. For people with an eGFR above 30 ml/min/1.73m², they will also be offered modified

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					release metformin as initial therapy. For people with an eGFR between 20 ml/min/1.73m ² and 30 ml/min/1.73m ² , we have added a DPP-4 inhibitor to the recommendation to ensure that there is additional treatment to provide glycaemic reduction for this group. Thank you for your input.
NHS Birmingham and Solihull ICB	Visual summary	002		Overall this is very clear and easy to follow especially compared with earlier versions. Adding glycaemic targets/treatment thresholds would be helpful	Thank you for your comment. The committee agreed that glycaemic targets should be personalised. The committee did not want to set values for HbA1c as they did not review evidence related to this and therefore believe that this would not result in better care for people with type 2 diabetes.
NHS Birmingham and Solihull ICB	Guideline	009	018	1.7.3 - Guidance from NICE on the use and practical interpretation of fructosamine is missing from the guideline and would be welcome e.g. should we apply a conversion factor when measuring fructosamine to get HbA1c? (This is a common query in primary care as QOF only recognises HbA1c). How do HbA1c targets translate to fructosamine targets in the NICE guidance? In our population we are seeing increasing number of patients with variant Hb so this is becoming more of an issue in diabetes management.	Thank you for your comment. This is out of scope for the guideline update.
NHS Birmingham and Solihull ICB	Guideline	016	012-014	1.8.6 ACE/ARB drugs should also be included in the sick day recommendations	Thank you for your comment. The list is non-exhaustive and therefore ACE/ARB drugs would be included as options. Guidance about the properties of specific medicines (including others that are more likely to cause acute kidney injury when someone is dehydrated, such as diuretics and NSAIDs) is provided in the BNF.

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NHS Birmingham and Solihull ICB	Guideline	018	004	1.8.9 – there is no mention of the need to apply some caution when initiating SGLT2 in patients with very high Hba1c to avoid precipitation of DKA. We apply a cautionary threshold of 86 mmol/mol locally.	Thank you for your comment. The committee considered adding advice about SGLT-2 and people with high baseline glucose levels. They ultimately agreed that the concern in this scenario is more about managing the causes of the adverse events, such as dehydration and volume depletion, that can increase the risk of events such as diabetic ketoacidosis. Given this then updated the recommendations in the section about “Preventing diabetic ketoacidosis when taking SGLT-2 inhibitors” to give warning about this. They acknowledged that while a high baseline HbA1c can be a concern for starting an SGLT-2 inhibitor, it was not an absolute contraindication, and each case should be considered on a case by case basis.
NHS Birmingham and Solihull ICB	Guideline	018	004	1.8.9 – add a recognition that glycaemic benefit of SGLT2 is diminished when eGFR < 45 and that additional diabetes therapy may be warranted, noting however that the SGLT2 should be continued for its added non-glycaemic benefits (CKD)	Thank you for your comment. We agree and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .

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NHS Birmingham and Solihull ICB	Guideline	018	004	1.8.9 – add advice to use SGLT2 with lowest acquisition cost (currently generic dapagliflozin)	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Birmingham and Solihull ICB	Guideline	019	009	1.8.15 - Subcutaneous semaglutide – some clarity on dosing will be welcome here, i.e. whether to stop at or is the intention to go up to 2.4mg? Clinicians will be thinking of using Ozempic® but the stronger evidence is for Wegovy® at 2.4mg dose which is licensed for CV risk reduction (in established CV	Thank you for your comment. A dose clarification has been added that subcutaneous semaglutide (Ozempic), up to 1 mg per week should be offered (this excludes the new 2 mg dose of Ozempic that is being released in the future). Ozempic is

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				and a BMI > 27) in patients without diabetes, and is currently restricted to weight loss/obesity use in NICE TA 875. Better CVD benefit was shown with later trials of semaglutide (SELECT), however the participants had obesity and CVD, so BMI should be specified. When used at standard doses (up to 1mg in the UK) as may be done in clinical practice, the evidence for MACE risk reduction with semaglutide is also available for other GLP1s (SUPASS-CVOT for tirzepatide, REWIND for dulaglutide, LEADER for liraglutide) – see meta-analysis. Through singling out sc semaglutide, is it the intention of NICE that patients with ASCVD on other GLP1s be switched over to this product? What would clinicians be expected to use in place of sc semaglutide if there were widespread shortages, as we have had recently? In view of the availability of lower cost biosimilar liraglutide now on the market, it may be prudent to advise use of liraglutide, dulaglutide, or sc semaglutide for patients with T2DM and ASCVD, as per EASD (2022), as a way to mitigate against cost and supply pressures.	licensed for the indication being discussed (management of type 2 diabetes). Of the trials you mention, only the data from REWIND was included in the analysis for people with atherosclerotic cardiovascular disease. The data from LEADER was included in the analysis for people with higher risk of CVD and people with heart failure, and not enough evidence was received for the SURPASS-CVOT trial to assess cardiovascular and renal benefits for tirzepatide in people with atherosclerotic cardiovascular disease. The SELECT trial included a population of obesity and not type 2 diabetes. Of the GLP-1 receptor agonists and tirzepatide where we had evidence, only subcutaneous semaglutide showed clinically important evidence of cardiovascular and renal protection and glycaemic benefits alongside a potentially beneficial weight reduction side effect while also being cost effective for people with atherosclerotic cardiovascular disease. Therefore, we have only recommended subcutaneous semaglutide rather than other GLP-1 receptor agonists or tirzepatide for people with atherosclerotic cardiovascular disease at this time. The choice should be given to people with type 2 diabetes as to whether they want to switch medicine. If they are stable and having benefits with other medicines then they can remain on the same treatment. However, this may be associated with less cardiovascular and renal protection benefits.

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					The committee have decided to make recommendations based on the most clinically and cost effective treatments based on the evidence. They have done this rather than making recommendations based on potential shortages.
NHS Birmingham and Solihull ICB	Guideline	019	009	There is no mention of retinopathy risk and need for retinal screening when using semaglutide	Thank you for your comment. The retinopathy risk with semaglutide is included in the BNF. The expectation is that all prescribers would be aware of the guidance in the BNF for the products that they are prescribing. General guidance about retinal screening can be found in the section on "Eye disease" that has not been updated as a part of this guideline update and guidance about diabetic retinopathy can be found in NICE's guideline on diabetic retinopathy , and a cross-reference to this has been added to the section on How to introduce medicines.
NHS Birmingham and Solihull ICB	Guideline	019	009	The cost pressure from increased use of GLP1s as instructed here will be significant in ICBs with populations of high prevalence of DM and CVD, especially as there is no longer any BMI threshold	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease.
NHS Birmingham and Solihull ICB	Guideline	019	013-015	1.8.17 - Subcutaneous semaglutide – is this the 2.4mg dose? What would clinicians be expected to use in its place in the event of an extended national shortage, as seen in recent months?	Thank you for your comment. A dose clarification has been added that subcutaneous semaglutide (Ozempic), up to 1 mg per week should be offered (this excludes the new 2 mg dose of Ozempic that is being released in the future). Ozempic is

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					licensed for the indication being discussed (management of type 2 diabetes). Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather for people with atherosclerotic cardiovascular disease at this time.
NHS Birmingham and Solihull ICB	Guideline	019	013-015	The cost pressure from increased use of GLP1s in this cohort will be significant especially as there is no longer any BMI threshold	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease.
NHS Birmingham and Solihull ICB	Guideline	020	005	1.8.18 – EOT2DM – we appreciate having guidance in this area. Does the recommendation on GLP1-RAs extend to younger adults (18-25 yr) with T2DM +/- obesity? Overall, small trials show that GLP-1 receptor agonists appear to be safe in children and adolescents with diabetes and obesity and some are licensed in this cohort, however, longer-term follow-up studies are needed to assess effects on growth, as loss of muscle mass is important in	Thank you for your comment. The guideline covers people with type 2 diabetes 18 years and older, however, we did not find any specific evidence for adults 18 to 25 years that met our review protocol. The committee identified this as a gap in the evidence and therefore made a research recommendation around treatments for people with early-onset type 2 diabetes.

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				adolescents. We acknowledge that the NICE guidance is for adults with T2DM (age > 18).	
NHS Birmingham and Solihull ICB	Guideline	020	005	This recommendation may also lead to considerable increased prescribing pressure following wider use of GLP1-RAs in ICBs with a young population and high prevalence of diabetes, as the case in BSol, especially if there is no longer any BMI threshold to apply.	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease.
NHS Birmingham and Solihull ICB	Guideline	020	005	We recognise that tight glycaemic control in this population is vital and programmes to get people's diabetes into remission should be particularly emphasised here	Thank you for your comment. This is out of scope however we have included a new recommendation at the start of the medicines section to highlight the importance of a discussion around healthy living and diet.
NHS Birmingham and Solihull ICB	Guideline	021	010, 011, 016	1.8.24 and 1.8.26 – offer dapagliflozin in preference (lower acquisition cost)	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be

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					equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Birmingham and Solihull ICB	Guideline	022	001-002	1.8.27 For eGFR < 20 consider a DPP-4i: That depends on diabetes control, if HbA1c is high, they will require insulin anyway, the DPP4i will be insufficient	Thank you for your comment. We mostly agree with you. The committee have recommended DPP-4 inhibitors for people with eGFR 20 ml/min/1.73 m ² because they are effective at reducing HbA1c and have fewer adverse effects than other options such as insulin. The recommendations for further treatment state that pioglitazone or an insulin-based treatment should be considered if they are not effective at controlling a person's HbA1c. This recommendation is a weaker 'consider' recommendation acknowledging that there is uncertainty in specific situations, this may include where someone's HbA1c is particularly high where other treatments may be preferred, like insulin. However, the committee agreed that most of the time a DPP-4 inhibitor would be the most appropriate treatment to consider.

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NHS Birmingham and Solihull ICB	Guideline	022	003	- Note that (1) eGFR <30ml/min, pioglitazone may worsen fracture risk further and (2) there is risk of worsening of fluid retention/heart failure risk in GFR<30ml/min.	Thank you for your comment. As information on fluid retention, heart failure and fracture risk is covered in the drug's SPC, the committee decided that it was not necessary to revisit this recommendation. The expectation is that all prescribers would be aware of the guidance in the BNF and to take this into account for the drugs they are prescribing. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
NHS Birmingham and Solihull ICB	Guideline	022	019	1.8.32 – we appreciated the inclusion of a section on frailty, however HbA1c and BM thresholds (as per the International Diabetes Federation) would be useful to include in addition to advice about treatments to avoid or use with additional caution	Thank you for your comment. The committee has not made specific targets for each group as they have agreed that targets should be individualised for the person. This is discussed in the recommendations about HbA1c measurement and targets and focussed on in NICE's patient decision aid on type 2 diabetes: agreeing someone's blood glucose (HbA1c) target. Please see the "Treatment options if further medicines are needed" and rationale and impact section for this if you

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					require additional advice on treatments to use with additional caution.
NHS Birmingham and Solihull ICB	Guideline	025	007	1.8.41 – it would be useful to have some ongoing review and/or discontinuation criteria for GLP1s, even if deemed a pragmatic approach in the absence of clinical trial evidence	Thank you for your comment. Please see the recommendation starting “Stop GLP-1 receptor agonists if...”. Otherwise, wording has been added to state “individualised” next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes.
NHS Birmingham and Solihull ICB	Guideline	025	014-015	1.8.43 – ‘Stop the GLP1 if they do not help the person reach their glycaemic or weight loss target’ – perhaps the ‘or’ should be ‘and’. If a patient is on GLP1 for diabetes and has no improvement in glycaemic control, then it should be stopped otherwise it becomes solely a weight loss agent (unless it is being used for they have early onset DM or ASCVD?). Some longer term continuation and discontinuation criteria would be useful, including for patients who reach or surpass usual HbA1c goals (< 48 mmol/mol)	Thank you for your comment. Following stakeholder feedback, it was agreed to remove weight targets from the recommendation. Goals should be based on individualised goals. If surpassing usual goals then this should be considered on a case by case basis.
NHS Birmingham and Solihull ICB	Guideline	025	020	1.8.45 – useful to have this included here to match current practice	Thank you for your comment.

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NHS Birmingham and Solihull ICB	Guideline	031	019-020	Insulin treatment in preference to pio/SU due to increased risk of fractures, hypos and falls	Thank you for your comment. The risks have been noted in the recommendations and the rationale. There is already a recommendation noting about the risk of hypoglycaemia and falls for insulin and sulfonylureas.
NHS Birmingham and Solihull ICB	Guideline	033	016	1.8.65 – it would be useful to include the recommended place in therapy of ultra-long acting basal insulins (glargine and degludec) and the ultra fast-acting insulins (e.g. Fiasp®, Lyumjev®) as currently there is no mention of these products	Thank you for your comment. The committee agreed to change the insulin recommendations from drug level to class based recommendations owing to the withdrawal of specific insulin products from the UK market.
NHS Birmingham and Solihull ICB	Guideline	033	020	1.8.65 – it is helpful to see biosimilars and cost of acquisition feature here	Thank you for your comment.
NHS Birmingham and Solihull ICB	Guideline	034	009-013	1.8.67 and 1.8.68 – it would be useful to add the recommended frequency of review, target BMs and how to up-titrate the insulin doses as part of review, as many patients are left on static insulin doses for long periods of time	Thank you for your comment. The committee agreed that the frequency of treatment review will be determined on a case-by-case basis depending on the person's individual circumstances (for example: treatment for symptom management or increasing glycaemic control).
NHS Devon ICB	Guideline	015	001	The current NG28 recommendation 'if 2 drugs in the same class are appropriate, choose the option with the lowest acquisition cost' should be retained. The draft guidance will significantly increase prescribing costs. It is important to support the use of generic products and biosimilar products.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is

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					equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Devon ICB	Guideline	017	009	NICE TAs for SGLT2 inhibitors should be withdrawn. The TA recommendations are mandatory and conflict with the guidance recommendations. ICBs are required to offer all SGLT2 inhibitors in line with their TA recommendations. This prevents the use of dapagliflozin in preference to other SGLT2 inhibitors to enable cost savings associated with the recently licensed generic versions of dapagliflozin	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.

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				to be realised. The price of 28 day supply for dapagliflozin 10mg tablets has reduced from £36.59 to £13.92 (October 2025 Drug Tariff).	
NHS Devon ICB	Guideline	018	004	A SGLT2 inhibitor is recommended as an initial treatment for patients with no significant comorbidity. The rationale states 'there is no evidence identified for people with type 2 diabetes and a low risk of cardiovascular disease'. This recommendation increases the risk of side effects and will lead to an increase in prescribing costs which is not supported by evidence.	Thank you for your comment. We have added more information to the rationale regarding people with type 2 diabetes increased lifetime risk of cardiovascular disease compared to those people without diabetes and the benefits of taking an SGLT-2 inhibitor to aid risk reduction. The committee agree that no person with type 2 diabetes is truly at low risk of cardiovascular disease (some may be at lower risk relative to others, but all have a high level of lifetime risk of developing cardiovascular disease). We acknowledge the increased risk of side effects and prescribing costs. However, when balanced against the benefits we agreed that the benefits outweigh the potential harms. Benefits were seen in reducing the number of people dying from cardiovascular disease, having a heart attack or a stroke (3-item MACE) and hospitalisation for heart failure. 123 out of 1000 people have a 3-item MACE event over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by 8 to 16 people if an SGLT-2 inhibitor is used for 3 years. Meanwhile, 54 out of 1000 people are hospitalised with heart failure over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by 14 to 28 people if an SGLT-2 inhibitor is used for 3 years. These clinically important reductions were weighed against the chance that 10 to 100 in 1000 people would experience genital infections and 1 in 1000 to 1 in 10,000 people would experience rarer events like diabetic ketoacidosis or Fournier's

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					gangrene or severe infections. Given this, the committee agreed that in most cases the benefits outweighed the risks. They agreed that the risk of volume depletion is manageable, and that it would be uncommon for it to lead to diabetic ketoacidosis. They noted that these risks should be discussed with the person ahead of starting treatment. Furthermore, the committee agreed the benefits to reducing inequalities in providing SGLT-2 inhibitors and metformin as a part of standard therapy for most people with type 2 diabetes. Health inequalities have been highlighted that show that providing SGLT-2 inhibitors will provide net health benefits for people living in the lowest two quintiles of the index of multiple deprivation. By implementing this recommendation on a population level, where the default position is to provide the treatment and consider the exceptions where you should not, this will help to reduce health inequalities and ensure that the health of the whole population improves, reducing deaths, cardiovascular events, renal disease and glycaemic complications. We believe this is supported by evidence and will reduce the risk of people developing cardiovascular disease long term. Providing that option to people with type 2 diabetes is clinically and cost-effective and we believe that supporting people with diabetes to decide if this is best for them will lead to better outcomes long term.

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NHS Devon ICB	Guideline	018	014	An SGLT2 inhibitor is recommended in combination with metformin for patients with heart failure. The recommendation should be for dapagliflozin or empagliflozin, as these are the only SGLT2 inhibitors licensed for heart failure. This would be in line with the approach taken to patients with kidney disease (page 21, line 10) where only SGLT2 inhibitors licensed for chronic kidney disease (dapagliflozin, empagliflozin) are recommended.	Thank you for your comment. The current UK marketing authorisations for SGLT-2 inhibitors are for the treatment of adults with type 2 diabetes mellitus (T2DM). Heart failure is not a separately licensed indication in section 4.1 of the SmPC. However, section 5.1 of the SmPC includes data on heart failure outcomes, reflecting the regulatory assessment that these results are consistent with, and supportive of, the overall benefit–risk profile of SGLT2 inhibitors in T2DM. Therefore, it is appropriate to consider the benefits on heart failure outcomes within the scope of the approved indication when evaluating SGLT2 inhibitors for patients with T2DM. Given this, the committee agreed that a class based recommendation was appropriate in this circumstance.
NHS Devon ICB	Guideline	020	011	The recommendation for a GLP1 agonist for patients with early onset diabetes is not supportable. The committee discussion states 'No direct clinical evidence to base the economic findings on. Modelling for GLP-1 receptor agonists showed that they were above the threshold with ICERs ranging between £39,537 and £102,108. While the health economic analysis shows large ICERs, the inputs are very uncertain. The model was not made using many people with early onset type 2 diabetes and so may have limitations when considering the group'	Thank you for your comment. The committee considered the results and certainty of the evidence from the economic model as well as the health inequalities report. These are discussed in detail in the 'Committee Discussion' document. Given the paucity of evidence and uncertainty around outcomes a 'consider' recommendation was made. The committee also made a research recommendation for the early onset population to try and address the gap in evidence. It is also worth noting that, following the drop in liraglutide's list price, the ICER has decreased and now is approximately £22,000 per QALY gained.

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NHS Devon ICB	Guideline	021	011-012	The recommendation for patients with chronic kidney disease and EGFR > 30mls/min/1.73m ² is for dapagliflozin or empagliflozin alone if metformin is contraindicated or not tolerated. The SmPCs for dapagliflozin and empagliflozin state that their glycaemic lowering effects are reduced if EGFR < 45mls/min/1.73m ² and additional glucose-lowering agents should be considered if EGFR < 45mls/min/1.73m ² . Dapagliflozin or empagliflozin alone will not provide sufficient glycaemic control for patients with EGFR between 30 and 45mls/min/1.73m ² – this should be recognised in the guidance.	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .
NHS Devon ICB	Guideline	021	011-012	TA942 and TA1075 recommend empagliflozin and dapagliflozin in patients with type 2 diabetes and chronic kidney disease only as an add-on to optimised standard care (including ACE inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated. NICE guidance for chronic kidney disease (NG203) recommends for adults with CKD and diabetes (type 1 or type 2), offer an ACE inhibitor or ARB for patients with a confirmed ACR of 3mg/mmol or more. If dapagliflozin and empagliflozin are to be offered to all patients with CKD regardless of concomitant medicines or ACR, TA942 and TA1075 should be withdrawn.	Thank you for your comment. The update only covers medicines to treat type 2 diabetes. People with type 2 diabetes and CKD would still be expected to receive treatment for CKD in line with the recommendations in NICE's guideline on chronic kidney disease [NG203] .

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NHS Devon ICB	Guideline	025	013	Clear guidance on when to stop treatment with a GLP-1 agonist is required. The NG28 recommendation should be retained: 'Only continue GLP-1 mimetic therapy if the adult with type 2 diabetes has had a beneficial metabolic response (a reduction of at least 11 mmol/mol [1.0%] in HbA1c and weight loss of at least 3% of initial body weight in 6 months)'	Thank you for your comment. Please see the recommendation starting "Stop GLP-1 receptor agonists if...". Otherwise, wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes.
NHS Devon ICB	Guideline	027	004	The addition of sc semaglutide is recommended for patients with obesity and heart failure with preserved ejection fraction who need further medicines to reach their weight management target. If this is the sole purpose of prescribing sc semaglutide then it conflicts with TA875 (Semaglutide [Wegovy] for weight management) which recommends that Wegovy is prescribed within a weight management service and that treatment should be stopped if less than 5% of the initial weight has been lost after 6 months of treatment. Prescribing a GLP1 agonist solely for weight management purposes in primary care requires a fully resourced and funded implementation process and the commissioning of wrap-around care in line with the approach introduced for tirzepatide TA1026 by NHS England.	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
NHS England	General			People with a learning disability and autistic people experience significant health inequalities such as those as highlighted in LeDeR reports (Learning	Thank you for your comment and for raising this important point. NICE is aware of the health inequalities raised in the LeDeR reports and is committed to making improvements to

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				from Lives and Deaths of people with learning disability and autistic people) https://www.kcl.ac.uk/research/leder and so it is important that consideration is given to their particular needs and to ensuring equality of access, experience and outcomes in healthcare services. - We suggest including a reference to making reasonable adjustments to care on the basis of disability. This is a legal requirement in the Equality Act 2010 and is important to help you make the right diagnostic and treatment decisions for an individual. You can ask the person and their carer or family member what reasonable adjustments should be made. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need. Possible examples include; allocating a clinician by gender, taking blood samples by thumb prick rather than needle, providing a quiet space to see a patient away from excess noise and activity. Resources are available such as NHS England » Sensory-friendly resource pack and NDTi Green Light Toolkit 2022. - Ensuring information and advice is in formats that is accessible and can easily be understood is	reduce inequalities for people with learning disability and autistic people. NICE guidelines include core guidelines that serve to reinforce messages that are crucial to many of the guidelines that we produce, as is the case with a lot of the points that you raise in your important comment. Our guideline cross refers to NICE's guideline on patient experience in adult NHS services: improving the experience of care for people using adult NHS services, which discusses a number of these areas. People with a learning disability were considered as a specific population of interest while developing the guideline and the committee considered whether separate recommendations needed to be made throughout the process of recommendation writing. In response to the recommendations about metformin changing, a specific note was made to standard release metformin being available for people with swallowing difficulties in the rationale and impact section, which may be more likely for people with learning disabilities. Guidance is provided in the rationale about the NEWT guidelines to support practitioners to ensure that the correct care is provided in these cases. We thank you for your continued work and action in this area.

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				essential In line with the NHS England » Accessible information standard · Be aware of diagnostic overshadowing: This occurs when the symptoms of physical ill health are mistakenly either attributed to a mental health or behavioural problem or considered inherent to the person's learning disability or autism diagnosis. People with a learning disability or autistic people have the same illnesses as everyone else, but the way they respond to or communicate their symptoms may be different and not obvious. More information can be found in this guidance: NHS England » Clinical guide for front line staff to support the management of patients with a learning disability and autistic people – relevant to all clinical specialties	
NHS England	Guideline	General		General: We welcome the inclusion of chronic kidney disease as an important factor in treatment decisions. This reflects the high cardiovascular and renal risk in this population and aligns with current evidence on the need for tailored interventions.	Thank you for your comment. We appreciate your feedback.
NHS England	Visual summary			Very little about diet, and in particular the P2R programme. Also little reference to other supporting tools e.g. DWMP. This is a missed opportunity.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in

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				Obesity section needs clearer guidance as to which GLP-1 is recommended and dosing. Needs to link to align with other relevant guidance. CKD section needs guidance on when to stop metformin added. EOT2D section needs guidance as to the clinical indication for GLP-1, which therapy is advised and dosing. Heart Failure section – add information about risks with pio and need to stop if previously prescribed. ASCVD section – add detail as to name of GLP-1 and dose.	implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact sections of the guideline. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A NICE technology appraisal is currently in progress for digital technologies for multidisciplinary weight management [GID-HTE10077]. For people living with obesity and people with early onset type 2 diabetes, a class recommendation was made for GLP-1 receptor agonists or tirzepatide. However, the visual summary has now been updated to specify that in people with atherosclerotic cardiovascular disease, doses of subcutaneous semaglutide (Ozempic) up to 1 mg once per week should be used. In keeping with NICE style, the visual summary does not specify contraindications for metformin and pioglitazone in people with CKD and heart failure respectively, as prescribers

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					are expected to know about the guidance in the BNF and the particulars of medicine they are prescribing.
NHS England	Guideline	010	004-016	There is a lack of clear guidance about setting glycaemic targets. Although these should be personalised, it would be helpful to see the need for lower glycaemic targets in young people and in adults with recent onset T2D. This will help reinforce the need to escalate therapies rapidly/stat with dual agents – the sooner we achieve treatment to target, the greater the benefits in terms of reducing complications and adverse outcomes. There is a risk that in not giving clearer guidance here leads to acceptance of a treatment standard at 58mmol/mol, which is likely to be too high for many younger people.	Thank you for your comment. This section was amended for updating language only and was out of scope for this guideline update. The committee agreed that these targets should be personalised. This has been reinforced later in the guideline when discussing reviewing medicines to make this clearer. The committee does not want to set values for HbA1c as they do not have evidence to support this and do not believe this will be the best for care.
NHS England	Guideline	016	007	This refers only to glucose lowering therapies. Many people with T2D will also be prescribed BP and renoprotective medications for which sick day rules apply. Please add further guidance about this.	Thank you for your comment. The recommendation on sick day rules relates to each person's individualised treatment plan. Recommendations for other specific comorbidities is outside the scope of this update. We would note that concern should be taken for medicines that are more likely to cause an acute kidney injury if someone becomes dehydrated (for example: ACE inhibitors, angiotensin-II receptor blockers, NSAIDs, diuretics). Guidance about the properties of specific medicines is provided in the BNF.
NHS England	Guideline	018.	002-009	This section includes what changes to make where metformin is not tolerated or contraindicated but there is no guidance as to what to do when SGLT2	Thank you for your comment. We have made recommendations for metformin due to it commonly not being tolerated and this being a barrier to starting treatment raised by people with type 2 diabetes. We have not done the same with

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				is not tolerated or contraindicated. This should also be included in here.	SGLT-2 inhibitors as this is not raised as commonly and we do not have anything extra of value to add here without sounding repetitive (the guidance would be to give the other treatment or treatments recommended for that section without the SGLT-2 inhibitor similar to the metformin recommendations).
NHS England	Guideline	019	005-015	This section will cause great confusion between this guidance and the implementation of TA1026. There is no BMI threshold stated here and the dose of semaglutide is not stated. NICE needs to be much clearer as to where semaglutide (and Tirzepatide) sit by clinical indication, dosing schedule, and BMI threshold, across the different guidelines – T2D, obesity management and CVD. If everyone with established T2D and CVD should now be offered semaglutide, regardless of qualifying BMI, where does the clinical indication for Tirzepatide in TA 1026 now sit? Guidance here also needs to cover what to do when either SGLT2i or semaglutide are not tolerated or contraindicated, with the same applying for the sections headed People with early onset type 2 diabetes, People living with obesity, People with chronic kidney disease and People with frailty.	Thank you for your comment. We agree that this is confusing and so have adjusted the wording in this section. There is no BMI threshold as the medicine is not being prescribed for weight management in this guidance. Subcutaneous semaglutide is being recommended for cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. These side effects should be taken into consideration when assessing a person's requirements and decided if it is an appropriate medicine or not (for example a person living with underweight). Tirzepatide has now been included in the guideline in relevant places (see recommendations including "GLP-1 receptor agonists and tirzepatide").

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					We have not made recommendations about when SGLT-2 inhibitors are not tolerated or contraindicated as this is not raised as commonly by people with type 2 diabetes as when metformin is and we do not have anything extra of value to add here without sounding repetitive (the guidance would be to give the other treatment or treatments recommended for that section without the SGLT-2 inhibitor similar to the metformin recommendations).
NHS England	Guideline	021	006	We are concerned about the exclusion of GLP-1 receptor agonists as a second-line option for people with type 2 diabetes and CKD. Recent evidence from the FLOW trial demonstrates that semaglutide significantly reduces the risk of major kidney outcomes and cardiovascular events in this population. Semaglutide reduced the composite risk of kidney failure, substantial loss of kidney function, and death from kidney or cardiovascular causes by 24%, slowed eGFR decline, and reduced all-cause mortality by 20%. The KDIGO 2024 Clinical Practice Guideline recommends the use of a long-acting GLP-1 RA in adults with T2D and CKD who have not achieved individualised glycaemic targets despite metformin and SGLT2 inhibitor therapy, or who cannot use those medications (Recommendation 3.9.1)	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The differences from the KDIGO 2024 guideline are likely as health economics is not considered alongside the clinical evidence when making recommendations. The population in this study people living with obesity CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).

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				Excluding GLP-1 RAs from the guideline risks creating a gap between NICE recommendations and international best practice, potentially disadvantaging UK patients with CKD and T2D. We recommend NICE revisits this position and considers incorporating GLP-1 RAs as an option for patients with CKD, particularly in light of the FLOW trial data and KDIGO guidance.	
NHS England	Guideline	021	006	The use of SGLT2 is with reduced eGFR is for renoprotection, rather than glucose lowering (as these therapies have limited glucose lowering in presence of more advanced CKD). This needs to be clearly stated, with direction toward alternative glucose lowering agents, then may need considered at the same time or soon after the addition of SGLT2i, where improvement in glycaemic control is required.	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .
NHS England	Guideline	022	001	The current wording in the document suggests that when eGFR falls below 20 ml/min, a DPP4 inhibitor is preferred over an SGLT2i. This could be interpreted as meaning SGLT2i should be stopped at eGFR < 20 ml/min.	Thank you for your comment. We appreciate your point. However, these points are discussed in the BNF and SPC. Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for prescribed medicines. These are

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				- KDIGO CKD 2024 guidance makes it clear that: SGLT2i should be continued even when eGFR is < 20 ml/min, right up until renal replacement therapy (RRT) is started, or unless the patient cannot tolerate them. - Without this clarification, the guideline risks encouraging an unnecessary and premature switch away from SGLT2i below eGFR 20 ml/min. "SGLT2 inhibitors should be continued, even when eGFR falls below 20 ml/min, until the initiation of renal replacement therapy or unless not tolerated."	explained in the SPC for the medicine or the British National Formulary (BNF). This applies to all medicines for NICE guidelines and so recommendations do not state this information.
NHS England	Guideline	022	019	Where possible, therapies associated with increased risk of hypoglycaemia should be avoided/minimised.	Thank you for your comment. The committee somewhat agree. The committee have concluded that there may be roles for treatments such as sulfonylureas and insulin, which are associated with increased risk of hypoglycaemia. However, they should be used with caution and considered for how appropriate they are for the person on a case by case basis. A recommendation was made around the risk of hypoglycaemia and falls for people living with frailty in the treatment options if further medicines are needed section.
NHS England	Guideline	025	007	"If the person has reached their glycaemic and weight targets, consider continuing any medicines	Thank you for your comment. In the type 2 diabetes guideline, treatments are primarily being provided to achieve

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				that have contributed to this" – this is contrary to NICE TA875 in the use of semaglutide in obesity and discontinuing after two years. Could this be clarified?	cardiovascular and renal protection and glycaemic benefits. These medicines may influence weight as a beneficial side effect (for example: semaglutide is being given outside of the weight management dose and formulation, but weight reduction effects may be seen with a smaller dose as found in this guideline). All medicines should also be given alongside dietary advice and healthy living, which can also influence weight. However, healthcare professionals are advised in the rationale that this is not the primary effect of the medicines at the formulation and dose prescribed in the guideline. If weight management is a primary goal then we would recommend that people refer to the overweight and obesity management guideline, which would align with the NICE TA875 as discussed.
NHS England	Guideline	025	013	I am unsure about why a weight target has been brought into diabetes guidelines and this confuses the indication for GLP-1 agonists. Please could NICE clarify what the primary objective should be for prescribers. I am also concerned about stopping GLP-1 receptor agonists if even partly being used for weight purposes as there is good evidence of weight re-gain which has a deleterious effect on diabetes control.	Thank you for your comment. We acknowledge that this has caused confusion and have made amendments to the guideline to make it clearer where the type 2 diabetes guideline and the overweight and obesity guideline sit in alignment to each other. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on

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					overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. With regards to the effects on weight re-gain, the committee agreed that this is a concerning effect of the treatment. This is why they recommended that any treatment that has helped the person to reach their individualised glycaemic target or weight target should be continued, in order to reduce the risk of this. While GLP-1 receptor agonists are not being used primarily for weight loss, they will most likely influence weight whether it is the aim or not. Given they are being prescribed for people who may benefit from weight loss, including people living with obesity, acknowledging the effect is important. Given that the mechanism for reducing HbA1c may be multifactorial, related to the direct glucose-centric mechanism of the medicine and the weight loss itself, acknowledging the effect is important (as otherwise this ignores the important glycaemic events that can occur if the medicine is stopped and their weight increases, as you note in your comment) . However, we agree that if the primary aim is to manage their weight, and gain access to the higher doses of treatments that are required to support with this, then access to treatment should be achieved through the pathways for the overweight and obesity management guideline.
NHS England	Guideline	027	002	This section is also likely to cause confusion with TA1026, as no qualifying BMI is listed as to eligibility for GLP-1 analogue.	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the

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				Guidance lacks clarity as to preferred GLP-1 analogue in this clinical indication. This should be stated, and the recommended dosing.	doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
NHS England	Guideline	027	002	This should be in an obesity guideline given that it is discussing weight targets and again may cause confusion about whether prescribing Ozempic or Wegovy.	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
NHS England	Guideline	029	011	There is no qualifying BMI listed here and no direction as to which agent should preferentially be prescribed. This will cause significant confusion for clinicians with no linkage or relationship to the TAs for both semaglutide and Tirzepatide. Everywhere these therapies are mentioned, a BMI threshold should be clearly stated.	Thank you for your comment. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we

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					recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. As we have clarified that these treatments are being given for their glycaemic benefits and providing links to the overweight and obesity management guidelines, we hope this should reinforce healthcare professionals and yourself that there is clear delineation between the pathways here. BMI thresholds are not needed in the type 2 diabetes guideline itself, as the reason for use is not based on weight (apart from for defining whether someone is living with obesity, for which people are directed to the overweight and obesity management guideline for the definition). The guideline acknowledges that these medicines may also have an effect on weight, which may be desirable for people with diabetes and those supporting them with their care.
NHS England	Guideline	033	013	This talks about shared decision making but then directs choice of insulin and suggests preference for premixed preparations. The decision here needs to take account of patient preference.	Thank you for your comment. In the recommendation the considerations that inform choice of basal insulin preparation include factors related to patient choice, such as whether they have a strong preference for once-daily injections or if they prefer injecting insulin immediately before a meal. The list of considerations related to choice of basal insulin preparation is not exhaustive, and the person may have other considerations that should be taken into account. The shared decision making, which is linked to in the guideline, offers guidance on

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					how to incorporate person preference into the decision making process.
NHS England	Guideline	044		Refers to isCGM, which is now obsolete, with all devices being rtCGM.	Thank you for your comment. This rationale discusses evidence in 2022 and is out of scope for this guideline update. The wording is retained to show what was being discussed at the time.
NHS England	Guideline	057		This whole section requires clarity, including much greater detail on clinical indication and dosing, and where the recommendation sits in relation to NG246, TA1026 and TA875, all of which now need updated to reflect the positioning with respect to the NICE recommendations for s.c. semaglutide in NG 28. This guidance states: Evidence showed that subcutaneous semaglutide was the only cost-effective 6 GLP-1 receptor agonist.... Other GLP-1 receptor agonists did not achieve this. As a result, the committee agreed to specifically recommend subcutaneous semaglutide rather than any other GLP-1 receptor agonist. Much clearer guidance is needed here and across all the above guidelines and TAs.	Thank you for your comment. We appreciate that this has caused confusion and have made edits to the guideline to address this. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. Weight loss associated with GLP-1 receptor agonists or tirzepatide can be a beneficial side effect that may be important to the person with type 2 diabetes. NG246 is the overweight and obesity management guideline, while TA1026 and TA875 are for people living with overweight and obesity and not explicitly people with type 2 diabetes.

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					As we have clarified that these treatments are being given for their glycaemic benefits and providing links to the overweight and obesity management guidelines, we hope this should reinforce healthcare professionals and yourself that there is clear delineation between the pathways here. BMI thresholds are not needed in the type 2 diabetes guideline itself, as the reason for use is not based on weight (apart from for defining whether someone is living with obesity, for which people are directed to the overweight and obesity management guideline for the definition). The guideline acknowledges that these medicines may also have an effect on weight, which may be desirable for people with diabetes and those supporting them with their care.
NHS England	Guideline	064		There is no reference to GLP-1 RAs here, which is extremely confusing.	Thank you for your comment. The reference to GLP-1 receptor agonists for people living with obesity can be found in the section titled 'Treatment options if further medicines are needed' under the subheading 'People living with obesity'.
NHS England	Guideline	080	019-025	"Evidence showed that no GLP-1 receptor agonist reached the cost-effectiveness threshold in the base-case analysis for people living with obesity. However, the committee considered sensitivity analyses where the price for liraglutide reduced further following the expiration of the medicine's patent in November 2024. It became cost-effective when the price reduced by 35%. Given this, they agreed that there was potential for GLP-1 receptor agonists to be cost effective under specific circumstances".	Thank you for your comment. We appreciate that this has caused confusion and have made edits to the guideline to address this. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the

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				This contradicts TA1026 and TA875. No qualifying statement re BMI. Very confusing across the different guidelines.	relevant technology appraisals. Edits have been made to the guideline to reinforce this. Weight loss associated with GLP-1 receptor agonists or tirzepatide can be a beneficial side effect that may be important to the person with type 2 diabetes. TA1026 and TA875 are for people living with overweight and obesity and not explicitly people with type 2 diabetes. As we have clarified that these treatments are being given for their glycaemic benefits and providing links to the overweight and obesity management guidelines, we hope this should reinforce healthcare professionals and yourself that there is clear delineation between the pathways here. BMI thresholds are not needed in the type 2 diabetes guideline itself, as the reason for use is not based on weight (apart from for defining whether someone is living with obesity, for which people are directed to the overweight and obesity management guideline for the definition). The guideline acknowledges that these medicines may also have an effect on weight, which may be desirable for people with diabetes and those supporting them with their care.
NHS Greater Manchester ICB	Consultation questions		001	Implementation challenges: It is important to understand whether there could be challenges to implementing any of the draft recommendations. Notably, these could include: Early onset: Linking eligibility for treatments to age at diagnosis may present challenges in practice.	Thank you for your comment and your acknowledgements of the realities of clinical practice. We agree with this. While we have suggested a value for where early onset diabetes would be defined, there are going to be exceptions where treatments should be provided. Evidence has showed that risk is higher for this group, but this risk does not suddenly drop the moment you exceed it. If people are close to age boundaries, then this

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				Those who live in the most deprived areas are more likely to present late and therefore may be diagnosed after 40yrs even though they have been living with diabetes for some time. For example, a person with early onset T2D (who is very likely to be living with obesity) may be considered for a GLP-1 agonist, but a person with T2D living with obesity (diagnosed after 40 years) will not be.	should not be used to exclude people from treatment. The reason for highlighting this is to state that the lifetime risk of cardiovascular disease is very high in this group. Therefore, if it can be justified that the same is the case for an individual person, then there is no reason for them to be excluded treatment based on them not fitting into this criteria. As always, NICE guidelines are to support care and each person should be treated individually allowing for the autonomy of the healthcare professional to advocate for what is best for the person they are supporting. Thank you for your careful consideration on this matter.
NHS Greater Manchester ICB	Consultation questions		003	Impact on existing NICE technology appraisals: NICE should consider updating the existing technology appraisals for canagliflozin, dapagliflozin, empagliflozin, and ertugliflozin (TA288, TA315, TA336, TA390, TA418, TA572, TA583). There would be a benefit to streamlining the number of TAs for SGLT2 inhibitors, ensuring they are aligned where appropriate and retiring those that are no longer in keeping with best practice (ertugliflozin). When considering SGLT2 inhibitors as an initial treatment, there were gaps in the evidence for several cohorts. The evidence for group 5 was classed as having a high risk of imprecision and an extremely high risk of bias. Group 5 was noted to	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.

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				be the biggest but most heterogeneous group (including trials where a proportion of people had ASCVD). Therefore, if an update of the NICE TAs included specific consideration of the evidence and cost-effectiveness of SGLT2 Inhibitors for primary prevention of CVD, (in people who do not have established cardio-renal conditions), it would be welcomed.	
NHS Greater Manchester ICB	Guideline	General		Personalised approach with a focus on cardiovascular and renal outcomes: The increased focus on cardiovascular and renal outcomes is welcomed and brings NICE guidance more in line with global guidance/consensus.	Thank you for your comment. We appreciate your feedback.
NHS Greater Manchester ICB	Guideline	General		We consulted with the clinical community in primary and specialist care in the ICB area and have summarised the feedback and questions raised below: - Concern has been raised about focussing too strongly on specific products (e.g. injectable semaglutide) and the potential supply chain risks this could carry. - Does there need to be a quick reference to safety around SGLT2i e.g. use unless HBA1c >86mmol/mol, previous DKA etc? - On a positive note, it is well set out and easy to follow (unlike the current one) to support decision making. - Greater clarity is required in cases where	Thank you for your comment. Specific products NICE makes recommendations based on effectiveness and cost-effectiveness evidence. Safety Recommendations for preventing diabetic ketoacidosis (DKA) have been made including a person's previous episodes of DKA, diet and intercurrent illnesses. When subcutaneous semaglutide is not effective / not tolerated It is stated in the guideline that a DPP-4 inhibitor should be considered if a GLP-1 receptor agonist is contraindicated, not

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				subcutaneous semaglutide is not effective/not tolerated on what actions are proposed. - Regarding the use of SUs in patients with CKD & Frailty, we do still see Glimepiride and Gliclazide MR, so: - Can there be a caveat, recommending that Gliclazide be the SU of choice? - If we are to consider an SU in eGFR <30ml/min / patients >70yrs, can it be suggested that starting dose is no >than 40mgs od with cautious titration? - Try and avoid SU in patients with irregular eating patterns?	tolerated or appropriate where a person needs further medication to meet their glycaemic targets People with CKD and frailty Owing to a lack of evidence there is no one treatment recommended over another for people with frailty and that a medication review should be undertaken to optimise therapies according to a person's needs, lifestyle and comorbidities. Sulfonylureas are not recommended in this guideline for persons with eGFR below 30 ml/min/1.73m²
NHS Greater Manchester ICB	Guideline	General		Incretin mimetics: It would be helpful to incorporate the tirzepatide TA into the recommendations/visual summary. It needs to be clear in the guideline that 'GLP-1' and tirzepatide are not interchangeable. This would make the guideline more useable and useful. Where GLP-1 agonists were found NOT to be cost-effective, e.g. in those with T2D and no comorbidities, this should be stated within the recommendations section.	Thank you for your comment. The wording has changed to "GLP-1 receptor agonists or tirzepatide" to reflect where tirzepatide has a role in the guideline. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about cost effectiveness, users should refer to the rationale and impact sections of the guideline as well as the committee discussion document.

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				Choice of GLP-1 RA: Where the cost-effectiveness of using a GLP-1 RA is based on a particular product or pricing threshold, this should be consistently communicated within the guidance. Where the generic term GLP-1 RA is used, a statement should be added that the most cost-effective GLP-1 RA should be used. This would allow for the use of generic liraglutide, where clinically indicated and appropriate. It would be helpful to incorporate the tirzepatide TA into the recommendations/visual summary. It is important that the recommendations are considered in the context of managed access to tirzepatide for weight management. For example, for those with no comorbidities (and therefore not obese): As written, tirzepatide is available as a further option for HbA1c optimisation, but GLP1s, including liraglutide, were not considered cost-effective. This approach does not appear to support cost-effective allocation of resources based on clinical need. GLP-1 RA: Place of initiation and funding varies. This may happen in community services or in GP practice this could lead to variability in	We have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).

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				uptake/capacity planning implications that will need to be address.	
NHS Greater Manchester ICB	Guideline	General		Cost implications: It is important to consider whether implementation of any of the draft recommendations will have significant cost implications and whether these challenges will impact on the proposed (visual summary) or other pathways. Recognising the significant numbers of patients that this guidance will apply to, the impact of using SGLT2 inhibitors universally as an additional first line treatment from diagnosis should not be underestimated. The health inequalities briefing, which modelled different SGLT2 inhibitor uptake scenarios across conditions and co-morbidities, was helpful. The inclusion of opportunity costs is an important consideration. There are several limitations with the evidence that contribute to uncertainty and reduced confidence in the modelled outcomes. In studies, the cardiovascular benefits of SGLT2 inhibitors were seen in people with established cardiovascular disease and at the highest risk. It is not known if the same relative risk reduction will be realised for primary prevention in the wider diabetes population.	Thank you for your comment. The evidence showed that SGLT-2 inhibitors in combination with metformin were more effective than metformin alone in people with type 2 diabetes and no relevant comorbidities (Model 5 in the evidence review); this is highlighted in the rationale and impact section for Initial medicines: People with type 2 diabetes and no relevant comorbidities. We agree that there are uncertainties in the evidence with respect to the study populations, and studies in model 5 are likely to have included people with type 2 diabetes and atherosclerotic cardiovascular disease. These uncertainties have been highlighted in the committee discussion document along with other sources of uncertainty. While acknowledging these uncertainties, we have provided the best estimates based on the information available. We also acknowledge that the estimate about the early onset group is very uncertain and so may be an over- or under-estimate as we have no evidence for this group. The opinion from the committee was that the benefits in reducing lifetime risk are likely to be very large and are not captured by the current data.

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				The outcomes for group 5 were used as the basis for recommendations in: • No co-morbidities • Early onset • Obesity The evidence review (page 30) notes limitations in classifying the studies into population strata, 'there were a number of studies within the model 5 evidence in which a proportion of the people included in the studies may have established ASCVD.' The group 5 evidence was also classed as a high risk of imprecision and an extremely high risk of bias. Therefore, the projected outcomes over the 3 years of the costing template may have been overestimated in some cohorts, (and will differ depending on the baseline risk). There will also be significant cost implications from increased use of GLP-1RA and continuing use for CV outcomes in some cohorts. Clarification around cost-effectiveness and product choice will support an improved understanding of this.	Further information around the cost-effectiveness of different GLP-1 receptor agonists in different populations can be found in the health economic analysis report.
NHS Greater Manchester ICB	Resource impact template			Costing template/Capacity: The costing template suggests that two additional 20-minute appointments per year (band 6) will be required per	Thank you for your comment. Not sure if this is possible as we would need to know what criteria is used for level of risk.

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				person started on a GLP-1 RA. It would be helpful if the costing template included outcomes by co-morbidity for SGLT2 I or, if not possible, by level of risk, i.e. low, medium and high/v high. This would support decision-making and planning. Approximately 10% of people living with Type 2 diabetes in Greater Manchester are 'low risk.'	
NHS Greater Manchester ICB	Guideline	004	007	1.1.1 Personalised care approach: The personalised approach, with treatment tailored to co-morbidities, is supported. This will require effective shared decision-making respecting patient preferences. Decision support tools would support informed conversations about potential risks and expected outcomes of treatments and make the guidelines more useable and useful.	Thank you for your comment. This recommendation is outside of the scope of the guideline update and was not presented for comment during this consultation.
NHS Greater Manchester ICB	Guideline	014	n/a	1.8 Drug costs: A statement should be included that the drug with the lowest acquisition cost that is clinically appropriate for the patient should be used.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-

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					2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Greater Manchester ICB	Guideline	015	001	1.8.3 <i>Involving people in medicine discussions:</i> Guideline To undertake informed shared decision making, a breakdown of the potential risks and benefits by comorbidity or level of risk is needed. This should include a statement about the certainty of the evidence and the expected NNT. It would be useful to recommend the use of a patient decision aid e.g. GPevidence.org. or the BMJ Cardiovascular, kidney related, and weight loss effects of therapeutics for type 2 diabetes: a living clinical practice guideline The BMJ. This will give the patient and the clinician an understanding	Thank you for your comment. NICE is considering developing of a clinician discussion aid to help support implementation of this.

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				of the absolute benefits and harms of each medicine.	
NHS Greater Manchester ICB	Guideline	015	018-028	1.8.3 Pre-conception planning: Due to the increasing prevalence of early-onset diabetes and the earlier use of SGLT2 inhibitors and GLP-1 RA, access to contraception and pre-conception planning is particularly important and should form part of shared decision-making conversations.	Thank you for your comment. We agree and so included a recommendation to discuss contraception for people taking GLP-1 receptor agonists. For SGLT-2 inhibitors we do not comment specifically on this but we refer to the summary of product characteristics which refers to the current information published about the safety of SGLT-2 inhibitors in pregnancy.
NHS Greater Manchester ICB	Guideline	018	004	1.8.9 Risk levels: The NICE committee discussion states 'No evidence was identified for people with type 2 diabetes and a low risk of cardiovascular disease'. Cardiovascular risk rises with age, and even without any other risk factors QRISK3 classes people with type 2 diabetes as at high cardiovascular risk at age 52 (for men) and age 60 (for women). Additionally, although rare, SGLT-2 inhibitors are associated with serious side effects, i.e. risk of diabetic ketoacidosis and Fournier's gangrene, which have been subject to MHRA patient safety alerts. Adopting a more personalised and risk-based approach for SGLT2 inhibitors would be in keeping with the approach adopted for other medications. Given the low cardiovascular risk and absence of evidence, and that people with type 2 diabetes	Thank you for your comment. We have added more information to the rationale regarding people with type 2 diabetes increased lifetime risk of cardiovascular disease compared to those people without diabetes and the benefits of taking an SGLT-2 inhibitor to aid risk reduction. The committee agree that no person with type 2 diabetes is truly at low risk of cardiovascular disease (some may be at lower risk relative to others, but all have a high level of lifetime risk of developing cardiovascular disease). We acknowledge the increased risk of side effects. However, we believe that the reduction in risk of developing cardiovascular disease should be a consideration for people, with but with discussion of balancing this against the low likelihood of adverse events. For example: the risk of dying from cardiovascular causes from diabetes is 61 in 1000 according to our review, taking an SGLT-2 inhibitor can reduce this by 3 to 22 in 1000 over 3 years, while the risk of Fournier's gangrene and diabetic ketoacidosis is between 1 in 1000 and 1 in 10,000 according to the BNF. This should be balanced against the risk of less severe genitourinary infections which

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				should be reviewed annually, it would seem more appropriate to start only when indicated.	occurs in around 10 in 1000 to 100 in 1000. Providing that option to people with type 2 diabetes is clinically and cost-effective and we believe that supporting people with diabetes to decide if this is best for them will lead to better outcomes long term.
NHS Greater Manchester ICB	Guideline	019	005-009	1.8.15 Lower threshold: An inclusion of a defined lower threshold (adjusted for BMI) for GLP1-RA initiation would be useful for clinicians here as the current interpretation here could include people with a low BMI.	Thank you for your comment. The BNF states the side effects of decreased appetite and decreased weight for semaglutide. Therefore, these side effects should be taken into consideration when assessing a person's requirements and decided if it is an appropriate medicine for that individual or not (for example a person living with underweight). The committee have made a recommendation in the "Reviewing other medicines" section to recommend stopping GLP-1 receptor agonists and tirzepatide if the person taking it becomes underweight (BMI under 18.5 kg/m ²).
NHS Greater Manchester ICB	Guideline	019	009	1.8.15 Potential variation: The fact that currently there is no positive NICE TA for the use of semaglutide in the treatment of T2D in adults is problematic. Commissioners are mandated to commission the use of medicines in line with NICE TAs and are not legally required to follow NICE guidance. This may result in variation in uptake of these guidelines and subsequent inequalities in access to treatment.	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease. The recommendations written apply to services across England and Wales. We recommend that steps are taken to reduce inequity in access where this can be predicted and identified.

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NHS Greater Manchester ICB	Guideline	020	013	1.8.21 Potential for unintended consequences in other pathways: The NICE TAs/guidance for incretin mimetics in weight loss should be referenced within this guidance. Approximately 50% of people in Greater Manchester living with T2D are also living with obesity, and 80% of those eligible for tirzepatide under the weight management pathway have diabetes. Significant difference in access may have unintended consequences and negative impact (e.g. deliberately raising HbA1C levels) to gain access to alternative pathway routes to specific medicines.	Thank you for your comment. All treatments all have their intended use stated next to them, and the overweight and obesity management guideline is cross referenced appropriately throughout the guideline. The type 2 diabetes guideline does not provide an option for people to gain access to the weight management formulation of semaglutide (Wegovy). There is the potential to access other GLP-1 receptor agonists or tirzepatide for people living with obesity who require this for reaching glycaemic targets. However, the person must have been taking initial therapy for at least 3 months with further medicines needed. For this, they must have achieved the criteria in the 'How to introduce medicines' section where it states that medicines must be introduced one at a time ensuring tolerability at the maximum achievable dose. Therefore, if the guidance is followed correctly, this should give a fair assessment of clinical effect before assessing if the additional medicines are to be effective. There are multiple medicines the person would need to take in order to start a GLP-1 receptor agonist or tirzepatide by this pathway, so if the guidance is being followed appropriately, the chance of deliberately raising HbA1c would be limited.
NHS Greater Manchester ICB	Guideline	021	005-006	1.8.23 The evidence undertaken by NICE includes trials only up to March 2024: This means that some more recent studies are not included, e.g. CVOT study for oral semaglutide (SOUL Study), or the FLOW study data for injectable semaglutide. Whilst there is an acknowledgement of the scale	Thank you for your comment. The FLOW trial was already included in the review (as this was identified ahead of consultation). The SOUL study has now been added to the guideline (reassuringly this did not change the results). The committee agreed the current recommendations based on these and other trials.

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				and the complexity of the work undertaken by NICE, the final guidance may miss some important trials that could impact recommendations. For example, the use of GLP-1RAs in CKD is not recommended in the draft guidance, but the FLOW study provides strong evidence in support of improved outcomes in people with CKD. Including this evidence would increase the relevance of the guideline to a wider clinical community.	Regarding GLP-1 receptor agonists or for chronic kidney disease. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness. The population was people living with obesity living with CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
NHS Greater Manchester ICB	Guideline	021	012	1.8.24 Choice of SGLT2i: The guidance should state that only generic SGLT-2 inhibitors licensed for use in CKD should be used.	Thank you for your comment. We have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally

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					suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin). The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m².
NHS Greater Manchester ICB	Guideline	022 & visual summary	011-021	1.8.30 – 1.8.32 Frailty: The guidance suggests SGLT2 inhibitors should be avoided if the level of frailty places them at 1.8.30 increased risk of an adverse drug reaction from an SGLT2 inhibitor. As presented, there is a risk that some people with frailty who would benefit from an SGLT2 inhibitor may not have access. In the visual summary, the list of further treatments for those with frailty includes sulphonylureas, pioglitazone, and insulin. This could be misinterpreted as indicating that these are safer in frailty compared to an SGLT2 inhibitor (or GLP-1 RA).	Thank you for your comment. The committee believe this is appropriate. The concern with SGLT-2 inhibitors is about volume depletion, which can lead to significant life-threatening consequences and is more likely for some people with frailty taking SGLT-2 inhibitors. However, for sulphonylureas, pioglitazone and insulin, there are cases where these may be appropriate treatments, and the side effects are manageable through dose titration or selecting a different agent. Therefore, the committee believed that this was an appropriate interpretation of the guideline and did not opt to change this but clarified the adverse events that they were concerned about.
NHS Greater Manchester ICB	Guideline	025	015	1.8.43 Cost impact: For people without ASCVD, in practice, GLP-1s tend not to be discontinued but insulin added. This was acknowledged in the NICE TA for tirzepatide, and cost-effectiveness was	Thank you for your comment. The cost-effectiveness analysis assumed that GLP-1 receptor agonist therapy would continue unless discontinued, for instance, due to an adverse event.

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				modelled on that assumption. The cost/impact of continuing GLP1s should be incorporated or recommendations should include specific targets e.g. percentage weight loss or HbA1c reduction within a certain timeframe. For example, as per section 1.7.22 in the current guideline .	The committee noted that in individuals with atherosclerotic cardiovascular disease, the primary benefits of GLP-1 receptor agonists were cardiorenal protective. Wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes.
NHS Greater Manchester ICB	Guideline	025	020	1.8.45 Emphasis on important statements: 'Do not offer a GLP-1 receptor agonist and a DPP 4 inhibitor' is an important statement and should be emphasised; existing patients receiving them concurrently should be identified and reviewed.	Thank you for your comment and support of this recommendation. The committee agreed that concomitant use of GLP-1 receptor agonists and DPP-4 inhibitors should be considered when reviewing other medicines.
NHS Greater Manchester ICB	Guideline	027	001	Title change: This section should be headed 'People with heart failure with preserved ejection fraction' rather than specifying this in bullet point, line 8.	Thank you for your comment. The sections discussing heart failure include both preserved and reduced ejection fraction heart failure. Recommendations discussing subcutaneous semaglutide (where it explicitly states preserved ejection fraction heart failure) were the only ones that only apply to a specific type of heart failure. They have since been removed. This has been clarified in the section titles.
NHS Greater Manchester ICB	Guideline	028	002-004	1.8.49 Treating HbA1c when it remains high: In atherosclerotic disease semaglutide is the only agent recommended however tirzepatide now has evidence of CV benefit in this group (SURPASS CVOT). Therefore, in those where further treatment is needed (ie HbA1c remains above target) the next step could be to switch from semaglutide to	Thank you for your comment. While we have seen the initial findings from the SURPASS CVOT trial, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection while GLP-1 receptor agonists included in the review have shown this.

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				tirzepatide as potentially more potent than semaglutide, so likely to improve HbA1c/weight further without the need for additional agents. The guideline would be more useful to a wider range of stakeholders if the evidence search were updated to include more recent literature.	Subcutaneous semaglutide has shown both clinical and cost-effectiveness, therefore has been recommended. Any relevant studies such as the SURPASS-CVOT trial published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline
NHS Greater Manchester ICB	Guideline	029	011	1.8.54 Choice of GLP-1: The committee discussion includes the following two statements: <i>"Evidence showed that no GLP-1 receptor agonist reached the cost-effectiveness threshold in the base-case analysis for people living with obesity. However, the committee considered sensitivity analyses where the price for liraglutide reduced further following the expiration of the medicine's patent in November 2024. It became cost-effective when the price reduced by 35%. Given this, they agreed that there was potential for GLP-1 receptor agonists to be cost effective under specific circumstances."</i> and: <i>"Based on the clinical and cost-effectiveness evidence, the committee made a recommendation to offer subcutaneous semaglutide alongside SGLT-2 inhibitors for people with ASCVD and to consider adding it</i>	Thank you for your comment. We have amended the committee discussion for the second paragraph. The first paragraph was stating that there was a sensitivity analysis where GLP-1 receptor agonists are cost effective when liraglutide has a price reduction but is not making a statement either way about which GLP-1 receptor agonist should be considered, so this does not need adjusting. The committee have recommended that any GLP-1 receptor agonist or tirzepatide can be considered for people in this population given that all available GLP-1 receptor agonists showed glycaemic benefits and some cardiovascular benefits. The most clinically effective was subcutaneous semaglutide which was slightly over the threshold for cost-effectiveness. On the other hand, liraglutide was cost effective but was less clinically effective. Other GLP-1 receptor agonists and formulations of GLP-1 receptor agonists (such as oral semaglutide) were not cost effective and were comparatively less clinically effective. Tirzepatide was shown to be cost effective but did not have evidence for cardiovascular and renal benefits, which GLP-1 receptor agonists did have. This

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				<i>alongside SGLT-2 inhibitors for people with HF and living with obesity if further treatment is needed, in the latter group as a means to reach glycaemic targets".</i> The first comment implies that only generic liraglutide should be considered for this group (as presumably the price drop of liraglutide cannot be extrapolated to all GLP-1 agonists), and the second comment implies that only subcutaneous semaglutide should be considered for this group (based on clinical and cost effectiveness), yet the actual recommendation is "consider adding a GLP-1 agonist", implying that any GLP-1 agonist may be used.	produced uncertainty in the evidence. Given this, they made a weaker consider recommendation in this case.
NHS Greater Manchester ICB	Guideline	030	016	1.8.57 Alignment with NICE technology appraisal: TA924 does not align with this pathway for people with T2D living with obesity. TA924 states that tirzepatide is an option if '<i>triple therapy with metformin and two other oral antidiabetic drugs is ineffective, not tolerated or contraindicated</i>'. On this pathway, the person will be unlikely to have triple oral therapy - they will be on metformin, SGLT-2i and a GLP-1. Either this guideline pathway or TA924 needs amending so that they align.	Thank you for your comment. The wording discussing GLP-1 receptor agonists has now been changed to say "GLP-1 receptor agonist or tirzepatide" to show the role of tirzepatide in this population. The recommendation about the technology appraisal for tirzepatide has been removed as this medicine has now been added into the guideline. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the tirzepatide technology appraisal.(TA924).

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NHS Greater Manchester ICB	Guideline	042	001-004	Early onset T2 diabetes (diagnosis before 40yrs): The recommendation for further research from NICE is welcomed.	Thank you for your comment
NHS Greater Manchester ICB	Guideline	052	013	Treatment cost assumptions: @The expected outcomes are applied equally to those at high risk of CV disease and to those at low risk. The cost of adverse events such as DKA have not been incorporated into the modelling. Consequently, the overall assumptions about treatment costs being offset may be overstated.	Thank you for your comment. Diabetic ketoacidosis was one of four adverse events modelled in the base case (see section 2.3.4). A sensitivity analysis explored the impact of removing adverse events altogether from the model. We did not conduct any modelling in population at low risk of cardiovascular disease.
NHS Greater Manchester ICB	Guideline	052	024	Starting multiple medications: Whilst medicines may be prescribed and added to the patient record at the initial appointment, there are some risks with issuing two or more medications at the same time that may need to be mitigated. Given the large amount of information people need to process when they are diagnosed with diabetes, there is a risk that a proportion of patients may not start some their medicines in a sequential manner. There is a need to balance the risk of clinical inertia with the complexity of initial treatment and any risks from polypharmacy and the guideline could be more useful and useable if guidance on achieving this were included.	Thank you for your comment. We have adjusted the wording to reflect this.
NHS Hertfordshire	General			Given the financial pressures across the system, it is important that guideline changes have been assessed for affordability (and resource impact	Thank you for your comment.

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and West Essex ICB				clearly stated) as well as clinical and cost effectiveness. It is important that all recommendations whether offer or consider are clearly based on robust evidence of improved patient outcomes and cost-effectiveness which appears uncertain with some of the evidence and rationale presented. Prescribing guideline changes go through the local Area Prescribing Committee, clinical and cost effectiveness and cost pressures are considered, and in the current financial challenges approval isn't given if the change will lead to additional cost pressure unless robust patient outcome evidence and cost offsets are clear. It would seem appropriate that any revised recommendations for GLP-1 receptor agonists including semaglutide should go through the NICE technology appraisal process with clear information on clinical and cost-effectiveness and recommendations for each of the treatments and each of the proposed cohorts. As an ICB we are mandated to commission NICE TAs, however NICE guidelines are recommendations and aren't always embedded into clinical practice, especially if associated with uncertain patient outcome evidence and a cost pressure that cannot be afforded. This could lead to variation between areas.	

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NHS Hertfordshire and West Essex ICB	Guideline	014	016	In the section on 'Medicines' a statement regarding choosing the lowest cost medication that is clinically appropriate, particularly for GLP-1s, would be helpful and support the wider approach within ICBs.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Hertfordshire	Guideline	018	004	Given the risk benefit balance, is it cost-effective to include in the guidance to start SGLT-2 inhibitors on	Thank you for your comment. We have added more information to the rationale regarding people with type 2

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and West Essex ICB				people with type 2 diabetes who are at low risk of cardiovascular disease?	diabetes increased lifetime risk of cardiovascular disease compared to those people without diabetes and the benefits of taking an SGLT-2 inhibitor to aid CVD risk reduction. The committee agree that no person with type 2 diabetes is truly at low risk of cardiovascular disease (some may be at lower risk relative to others, but all have a high level of lifetime risk of developing cardiovascular disease). We acknowledge the increased risk of side effects. However, when balanced against the benefits we agreed that the benefits outweigh the potential harms. Benefits were seen in reducing the number of people dying from cardiovascular disease, having a heart attack or a stroke (3-item MACE) and hospitalisation for heart failure. 123 out of 1000 people have a 3-item MACE event over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by 8 to 16 people if an SGLT-2 inhibitor is used for 3 years. Meanwhile, 54 out of 1000 people are hospitalised with heart failure over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by 14 to 28 people if an SGLT-2 inhibitor is used for 3 years. These clinically important reductions were weighed against the chance that 10 to 100 in 1000 people would experience genital infections and 1 in 1000 to 1 in 10,000 people would experience rarer events like diabetic ketoacidosis or Fournier's gangrene or severe infections. Given this, the committee agreed that in most cases the benefits outweighed the risks. They agreed that the risk of volume depletion is manageable, and that it would be uncommon for it to lead to diabetic ketoacidosis. They noted

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					that these risks should be discussed with the person ahead of starting treatment. Furthermore, the committee agreed the benefits to reducing inequalities in providing SGLT-2 inhibitors and metformin as a part of standard therapy for most people with type 2 diabetes. Health inequalities have been highlighted that show that providing SGLT-2 inhibitors will provide net health benefits for people living in the lowest two quintiles of the index of multiple deprivation. By implementing this recommendation on a population level, where the default position is to provide the treatment and consider the exceptions where you should not, this will help to reduce health inequalities and ensure that the health of the whole population improves, reducing deaths, cardiovascular events, renal disease and glycaemic complications. Providing that option to people with type 2 diabetes is clinically and cost-effective and we believe that supporting people with diabetes to decide if this is best for them will lead to better outcomes long term.
NHS Hertfordshire and West Essex ICB	Guideline	019	009 015	From a commissioning perspective it is important that the NICE guidelines align with NICE TA. At present there is no NICE TA for the use of semaglutide in treatment in type 2 diabetes and the NICE TAs do not have recommendations for the wider cohorts recommended in the draft guidance. There are also evidence and cost differences	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as

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				between the different treatments. It would seem appropriate that any revised recommendations for GLP-1 receptor agonists should go through the NICE technology appraisal process with clear information on clinical and cost-effectiveness and recommendations for each of the treatments and each of the proposed cohorts. As an ICB we are mandated to commission NICE TAs, however NICE guidelines are recommendations and aren't always embedded into clinical practice, especially if associated with uncertain patient outcome evidence and a cost pressure that cannot be afforded. This could lead to variation between areas.	less people will need to access services for care for subsequent cardiovascular disease. The recommendations written apply to services across England and Wales. We recommend that steps are taken to reduce inequity in access where this can be predicted and identified.
NHS Hertfordshire and West Essex ICB	Guideline	021	012	Rather than naming dapagliflozin and empagliflozin it would be helpful to state use a 'generic SGLT-2 inhibitors' that are licensed for use in CKD.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note

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					that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin). The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m².
NHS Hertfordshire and West Essex ICB	Guideline	027	001	For clarity it would be helpful to change the title to 'People with heart failure with preserved ejection fraction'. Otherwise, it relies on people reading to the end of the paragraph.	Thank you for your comment. The sections discussing heart failure include both preserved and reduced ejection fraction heart failure. Recommendations discussing subcutaneous semaglutide (where it explicitly states preserved ejection fraction heart failure) were the only ones that only apply to a specific type of heart failure. They have since been removed. This has been clarified in the section titles.
NHS Hertfordshire and West Essex ICB	Guideline	030	016	This recommendation does not align with NICE TA924, as the TA states people should be on triple therapy before tirzepatide is started. If this recommendation is followed it is unlikely they will be on triple oral therapy.	Thank you for your comment. The wording discussing GLP-1 receptor agonists has now been changed to say "GLP-1 receptor agonist or tirzepatide" to show the role of tirzepatide in this population. The recommendation about the technology appraisal for tirzepatide has been removed as this medicine has now been incorporated into the guideline. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of

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					the changes in this guideline update. NICE will consult on a review proposal regarding the update of the tirzepatide technology appraisal.(TA924).
NHS Hertfordshire and West Essex ICB	Guideline	032	020	Should there be a caveat regarding using sulfonylurea in people with frailty, due to the drug increasing the risk of falls and hypoglycaemia.	Thank you for your comment. The increased risk of hypoglycaemia and falls is raised in the recommendations about treatment options if further medicines are needed .
NHS Hertfordshire and West Essex ICB	Guideline	052	020	As an ICB we have projects on reducing medicine wastage and only ordering what you need, starting medications sequentially is potentially in conflict of this. Additionally, we have concerns of people understanding the instructions and taking the medications as intended.	Thank you for your comment. The committee decided that it was important to introduce medicines sequentially to enable any side effects and intolerances from the first drug to be identified before the second drug is introduced. The committee believed that this would not lead to a significant change in practice.
NHS North East London ICB	Guideline	General	General	We welcome and strongly support the updated guidance on the management of adults with Type 2 diabetes. The draft reflects the continued evolution of diabetes care and acknowledges the importance of personalisation, addressing inequalities, and integrating new treatments. We particularly value the recognition of SGLT 2 inhibitors in early pathways, the acknowledgement of lifestyle and remission focused approaches, and the commitment to patient centred care. In reviewing the guidance, we see opportunities to strengthen clarity, consistency, and alignment with other NICE outputs. We would encourage refinements that ensure the recommendations are practical, cost effective, and responsive to the	Thank you for your comment. Specific recommendations related to social factors, supporting family involvement, social prescribing and health coaching are outside of the scope of this update. NICE has other guidance to support individualised care and patient-centred approaches such as guidance on shared decision making [NG197] and patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138]. Education, lifestyle and diagnostics are also out of scope for this update. We have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into

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				realities of diverse patient populations and commissioning responsibilities. Individualised Care and Patient-Centred Approaches • We welcome the emphasis on care planning and shared decision making. Incorporating social factors—such as financial pressures, housing, or language barriers—would make this even more meaningful and help care feel more personalised. • Supporting family involvement is an important step, as lifestyle changes are most sustainable when embraced by households and communities, not just the individual. • The encouragement of social prescribing and health coaching reflects modern, multidisciplinary approaches to long term condition management and should be more prominent in the pathway. Education, Lifestyle and Remission • We support the strong place given to education. Building in cultural appropriateness, sensitivity to health literacy, and family inclusive learning will further support outcomes and equity. • Emphasising remission focused approaches is important, acknowledging that some patients can substantially improve outcomes with targeted diet	account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin). NICE recommendations should be action-based, and further information around the effectiveness and cost-effectiveness medicines in different populations can be found in the rationale and impact sections. Regarding tirzepatide, the wording has now been changed to say “GLP-1 receptor agonist or tirzepatide” to show the role of tirzepatide in this population. Thank you for your support around recommendations that GLP-1 receptor agonists and DPP-4 inhibitors should not be

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				and lifestyle interventions alongside medical therapy. • We suggest highlighting the value of accessible patient decision aids (e.g. GPevidence.org) to enrich shared decision making by illustrating absolute benefits and risks of treatment choices. Diagnostics and Precision Medicine • We welcome the growing focus on diagnosis and early precision. Broader use of C peptide testing and autoantibody screening could reduce misclassification and inappropriate prescribing. • Clearer guidance on glucose monitoring alternatives when HbA1c is not reliable would strengthen the section on blood glucose management and targets. Medicines and Treatment Pathways SGLT 2 Inhibitors • We welcome the greater recognition given to SGLT 2 inhibitors. To ensure sustainability and equity of access, guidance could usefully emphasise recommending generic formulations where available (currently dapagliflozin), providing future-proofing as more generics become available. • It may also be helpful to provide nuance around the groups most likely to benefit, reflecting differences in cost effectiveness and potential side	used together and that sulfonylureas can increase the risk of hypoglycaemia and falls. Locally appropriate BMI thresholds and culturally tailored interventions were outside the scope of this update. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact sections of the guideline. NICE currently has a patient decision aid for type 2 diabetes: agreeing my blood glucose (HbA1c) target. NICE is considering the development of a clinical discussion aid to support consultations in this area. The recommendations have been updated to state to stop GLP-1 receptor agonists if they do not help the person reach their individualised glycaemic targets and the person does not have atherosclerotic cardiovascular disease or early onset type 2 diabetes. Although optimal glycaemic targets are outside the scope of this update, NICE's guideline on Type 2 diabetes in adults: management [NG28] does have recommendations on individualised glycaemic targets and a patient decision aid for

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				effects. This would support clinicians in prioritising use where the evidence is strongest while aligning with NICE's own Health Inequalities analysis. GLP 1 Receptor Agonists • We support the recognition of GLP 1s but note the need for clarity in terminology—particularly to ensure that tirzepatide, a dual incretin agonist, is not unintentionally included under the term “GLP 1”. • Guidance could be strengthened by explicitly recommending the use of the most cost effective GLP 1 formulation that is clinically appropriate (e.g. generic liraglutide where suitable). • For consistency with earlier guidance (NG28), we suggest including explicit metabolic targets (e.g. HbA1c reduction and percentage weight loss within 6 months) as criteria for continuing treatment with tirzepatide • We value the inclusion of tirzepatide in the pathway and suggest adding clarification to ensure alignment with TA924. This will reduce potential confusion between this guidance and technology appraisal recommendations and support commissioners in consistent implementation. Other Medicines • We welcome the statement that GLP 1s and DPP 4 inhibitors should not be used together and agree that existing patients should be reviewed.	type 2 diabetes: agreeing my blood glucose (HbA1c) target to support this discussion.

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				• For frail patients, extra caution is warranted with sulfonylureas given risks of hypoglycaemia and falls. Prioritising gentler alternatives may enhance safety in this population. • More generally, it would be useful if the guideline consistently highlighted the principle that the lowest acquisition cost option, where clinically appropriate, should be used. Addressing Inequities and Local Context • We welcome the focus on inequalities. National guidance could be further enhanced by recognising local variation. For example, in high deprivation areas with diverse populations, locally appropriate BMI thresholds and culturally tailored interventions will be key to equitable outcomes. • Collaboration with Diabetes UK and regional stakeholders may provide a pragmatic route to ensuring guidance is responsive to these local needs, while retaining national consistency. Visual Summaries and Communication Tools • The inclusion of visual summaries is an important step forward. These could be even more valuable by ensuring they highlight both benefits and risks, as well as cost effectiveness considerations. Conclusions and Recommendations	

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				We commend NICE for producing a thorough and forward looking update to the Type 2 diabetes guidance. With a few refinements, it could be even more impactful. We particularly recommend: 1. Aligning recommendations closely with existing NICE TAs and NG246, with clearer terminology for medicine groups. 2. Prioritising lowest acquisition cost formulations (e.g. generic SGLT 2 inhibitors and GLP 1s). 3. Clarifying the distinct status of tirzepatide as a dual incretin agonist and ensuring pathway alignment with TA924. 4. Explicitly integrating remission focused, lifestyle, and family inclusive approaches across all sections. 5. Using patient decision aids and culturally tailored education to support meaningful shared decision making. 6. Offering stronger guidance on measurable criteria for continuation of therapies such as GLP 1s. 7. Embedding flexibility for local contexts to improve equity across diverse communities. By strengthening clarity and consistency, these adjustments would make the guidance even more practical for clinicians and commissioners, while enhancing equity and value for patients.	

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NHS North East London ICB	Guideline	General	General	National guidance does not always account for the needs of diverse urban populations. In areas such as North East London, with higher levels of deprivation and significant ethnic variation in risk profiles, more nuanced approaches are required—including consideration of different BMI cut-offs. We support working with Diabetes UK and other partners to articulate a regionally informed position that addresses inequities and advocates for locally relevant adaptations to centralised guidance.	Thank you for your comment. We have made a recommendation in support of this for SGLT-2 inhibitor use. By making a population-wide recommendation, we hope that this will reduce inequities in care by driving forward access for everyone. We have added a recommendation to request monitoring of groups using SGLT-2 inhibitors, identifying eligible groups who have a lower uptake and making plans to encourage use in those groups. By this we hope that we can increase use for people who have not been able to access SGLT-2 inhibitors but may be at higher risk of adverse outcomes, such as those identified in our report on inequalities.
NHS North East London ICB	Guideline	General	General	Our position is that diabetes care must move beyond rigid, one-size-fits-all pathways. By integrating modern diagnostics, earlier access to GLP-1s where clinically indicated, lifestyle-focused approaches, and locally tailored guidance, we can deliver safer, more effective, and more equitable care for our communities.	Thank you for your comment and your sound advice. We agree with you. The guideline highlights the complexity of type 2 diabetes and that people do not fit into one pathway. We have added recommendations to provide guidance to support people who have multiple comorbidities to reflect the reality that people with type 2 diabetes live with and to be support healthcare professionals. This update has expanded the use of GLP-1 receptor agonists as first-line therapy in people with early onset type 2 diabetes and people with type 2 diabetes with atherosclerotic cardiovascular disease. Diagnostics and lifestyle-focused approaches were out of scope for this update but NICE supports this through other programmes. Healthcare professionals should take local guidance into account alongside NICE guidelines, their clinical expertise, and patient preferences.

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NHS North East London ICB	Guideline	017-018	002-004	Recommendation 1.8.9 all T2DM patients to be offered initial treatment with metformin and an SGLT2i directly contradicts safety advice that SGLT2i published in July-25 SGLT-2 inhibitors Prescribing information Diabetes - type 2 CKS NICE) where emphasis that these should be offered on an individual assessment rather than a general approach given risks associated with prescribing. This again correlates with having additional and wider access to c-peptide testing to ensure safer prescribing.	Thank you for your comment. NICE recommendations set out the care and services that are suitable for most people with a specific condition. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20] . NICE has also provided information around making decisions using NICE guidelines . This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC) .
NHS North East London ICB	Guideline	020-021	012-015	Rec 1.8.21- consideration for GLP-1RA not stated here seems rather illogical, GLP1-RA should be available earlier in the treatment plan, rather than being reserved for later-line therapy. This would reduce unnecessary polypharmacy and allow clinicians to directly target the root causes of disease progression.	Thank you for your comment. While we appreciate the GLP-1 receptor agonists have a weight reducing effect, the aim of therapies in the diabetes guideline is primarily to provide cardiovascular and renal protection and glycaemic benefit. When being prescribed in this guideline, any weight reduction effects are considered a possible beneficial side effect as the dose and formulation may not be that licensed for weight reduction. If the aim of treatment is primarily for weight management then please see the overweight and obesity management guideline. Edits have been made to the guideline to reinforce this.
NHS North East London ICB	Guideline	018	001	Rec 1.8.9 to offer metformin and SGLT2i if T2DM and no significant comorbidity. NICE and trial evidence, network and pairwise meta- analyses largely support SGLT2i for	Thank you for your helpful comment. We agree there is a lack of clear rationale as to why the committee have made this recommendation and so we have added to the rationale. The committee agree that no person with type 2 diabetes is truly at

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				those with established CVD, CKD, or high risk. In low-risk patients, given committee states no evidence was identified for people with T2DM and low-risk of CVD we believe further progress is needed to ensure that treatment recommendations are flexible, evidence-based, and responsive to the diverse needs of our patient populations Therefore considering this should CV risk be assessed periodically and only initiate when indicated when risk increases... something to consider as will have significant cost impact.	low risk of cardiovascular disease (some may be at lower risk relative to others, but all have a high level of lifetime risk of developing cardiovascular disease). They also agree that a population wide recommendation is important for reduce inequities in care. By making a population-wide recommendation, we hope that this will reduce inequities in care by driving forward access for everyone. We acknowledge the increased risk of side effects. However, we believe that the reduction in risk of developing cardiovascular disease may be worthwhile balancing the lower likelihood of severe adverse events for most people. For example: the risk of dying from cardiovascular causes from diabetes in 61 in 1000 according to our review, taking an SGLT-2 inhibitor can reduce this by 3 to 22 in 1000 over 3 years, while the risk of Fournier's gangrene and diabetic ketoacidosis is between 1 in 1000 and 1 in 10,000 according to the BNF. This should be balanced against the risk of less severe genitourinary infections which occurs in around 10 in 1000 to 100 in 1000. The committee agreed that providing that option to people with type 2 diabetes is clinically and cost-effective and we believe that supporting people with diabetes to decide if this is best for them will lead to better outcomes long term.
NHS North East London ICB	Guideline	020	002-011	those with early onset type 2 diabetes rec 1.9.18: for adults with early onset offer metformin & SGLT2i and consider adding a GLP-1 RA this same consideration is not given to patients who are diabetic and living with obesity	Thank you for your comment. We agree that there are differences between these groups. People with early onset type 2 diabetes have a higher lifetime risk of developing cardiovascular and renal disease than people with later onset type 2 diabetes. While they may or may not also be living with obesity, the benefits from a GLP-1 receptor agonist are

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					primarily to provide heightened cardiovascular and renal protection in this case. This is explained in the rationale and committee discussion document.
NHS Nottingham and Nottinghamshire ICB	General			Is there sufficient clinical evidence of benefit to support primary prevention with SGLT2i in those without cardiac risk factors to endorse such widespread first line usage/ polypharmacy	Thank you for your comment. The committee discussed this and agreed that people with type 2 diabetes have cardiac risk factors (as type 2 diabetes is a cardiac risk factor). Taking into account the lifetime risk of cardiovascular disease or the QRISK score for different people, most people with type 2 diabetes are at high risk of developing cardiovascular disease. By making a population-wide recommendation, we hope that this will reduce inequities in care by driving forward access for everyone. We have added a recommendation to request monitoring of groups using SGLT-2 inhibitors, identifying eligible groups who have a lower uptake and making plans to encourage use in those groups. By this we hope that we can increase use for people who have not been able to access SGLT-2 inhibitors but may be at higher risk of adverse outcomes, such as those identified in our report on inequalities. While we acknowledge the risks of the SGLT-2 inhibitors, the committee agreed that balancing those risks against the benefits, this is likely to lead to benefits for most people. For example: the risk of dying from cardiovascular causes from diabetes is 61 in 1000 according to our review, taking an SGLT-2 inhibitor can reduce this by 3 to 22 in 1000 over 3 years, while the risk of Fournier's gangrene and diabetic ketoacidosis is between 1 in 1000 and 1 in 10,000 according to the BNF. This should be balanced against the risk of less

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					severe genitourinary infections which occurs in around 10 in 1000 to 100 in 1000. This was cost effective after taking into account the reduction in price of dapagliflozin. Therefore, they believe that primary prevention is appropriate for all people with type 2 diabetes. The effect of polypharmacy should be taken on a case-by-case basis and each person with type 2 diabetes should consider whether this is appropriate for them.
NHS Nottingham and Nottinghamshire ICB	General			Will the SGLT2i TAs be retired as continued existence introduces confusion as they are contradictory to this guidance? It was mentioned in the webinar that NICE are considering updating them. If the intention is to align with this guidance this would make the funding of any recommendation mandatory. May help with implementation and reducing inequity but also puts a financial pressure on the system.	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.
NHS Nottingham and Nottinghamshire ICB	Guideline	General		Generic liraglutide offers a cost-effective choice, but is not mentioned in the guidance. Could its place be clarified in a similar way to recommendations on biosimilar insulins?	Thank you for your comment. The committee agreed that liraglutide did not show comparable evidence of clinical effectiveness in providing cardiovascular and renal protection and weight reduction when compared to subcutaneous semaglutide, which showed clinically important reductions for some populations. Given this, they did not want to recommend it in the same position. Where recommendations are on a class level they agreed that all GLP-1 receptor agonists and tirzepatide could be recommended, acknowledging the limited evidence of clinical and cost effectiveness being relative

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					between the medicines and making weaker consider recommendations.
NHS Nottingham and Nottingham's hire ICB	Methods	General		Clarification of dosing for SC semaglutide. 2mg dose is licensed in the UK but double the cost of 1mg. Which dosing was used in costings to determine cost effectiveness? Is 2mg dose considered cost effective and therefore endorsed?	Thank you for your comment. The 1mg dose has been considered in the costings and the wording in the guideline has been updated to state subcutaneous semaglutide (Ozempic) up to 1 mg per week is recommended.
NHS Nottingham and Nottingham's hire ICB	Resource impact template			Could a section be added that costs out the recommendation for semaglutide for those with heart failure and obesity?	Thank you for your comment. We have focused our workings on the initial treatments where significant resource impact is expected. The recommendation for semaglutide for those with obesity is a consider recommendation when further treatment may be needed. This recommendation for heart failure been removed as the dose used in the STEP-HFpEF DM trial was the dose for weight management (2.4 mg weekly) and in balancing the factors together, it was agreed that further evidence was required before making a specific recommendation for people with heart failure.
NHS Nottingham and Nottingham's hire ICB	Guideline	018-020		Where an SGLT2i is recommended, could a statement be added to support using the SGLT2 with the lowest acquisition cost (i.e. dapagliflozin currently)	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-

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					2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Nottingham and Nottinghamshire ICB	Guideline	018-019		Could it be clarified that SC semaglutide (where specifically recommended) was the only GLP-1 found to be cost-effective i.e. to try and avoid scope creep with other GLP-1 or GLP-1/ GIP which may not be a cost effective alternative.	Thank you for your comment. Where this is appropriate for the relevant sections, subcutaneous semaglutide is the only recommended treatment. Where we believe all GLP-1 receptor agonists or tirzepatide could be used and could be considered a cost effective alternative, we have made this clear.
NHS Nottingham and Nottinghamshire ICB	Guideline	019		The recommendations within the guidance around increased access to GLP-1's e.g. 1.8.15, 1.8.47 will come with a significant cost for the system. There are concerns about the affordability of this and therefore ability to implement these recommendations. There is likely to be regional variability and therefore inequity of access because of the financial impact involved.	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease. The recommendations written apply to services across England and Wales. We recommend that steps are taken to

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					reduce inequity in access where this can be predicted and identified.
NHS Nottingham and Nottinghamshire ICB	Guideline	020		It is unclear how tirzepatide fits into the prescribing pathway. It could be implied that it is second line to GLP-1 which should be emphasised if that is the case.	Thank you for your comment. We have added in the term 'GLP-1 receptor agonist and tirzepatide' to make it clearer where tirzepatide is included with GLP-1 receptor agonists in recommendations and where it is not throughout the guideline.
NHS Nottingham and Nottinghamshire ICB	Guideline	027	002	Recommendation 1.8.47 implies that semaglutide is being used as a treatment for obesity as it is recommended for those not achieving weight management targets, whereas in other patients with obesity it is recommended for glycaemia targets. Is this recommendation in line with other NICE recommendations for obesity treatments? eg concomitant behavioural support needed. This recommendation is not consistent with National arrangements for access to GLP-1 therapies for obesity and therefore introduces a potential inequity.	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
NHS Nottingham and Nottinghamshire ICB	Guideline	027	002	Could it be clarified earlier in this recommendation that it is specifically Heart Failure with Preserved Ejection Fraction?	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is

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					appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
NHS Nottingham and Nottinghamshire ICB	Visual summary and guideline	027 029		Definition of obesity needed, i.e. clarification of BMI at which patients are eligible e.g. BMI>35kg/m2	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about BMI definitions can be found in the main guideline document.
NHS South East London ICB	Guideline	General		In broad agreement with the guideline as there is a clear evidence base for each recommendation. Main concerns would be the acceptability of introducing 2 or even 3 medications over a short time frame especially in cases where a GLP-1 is also recommended. It is possible that there may not be full take up by all patients	Thank you for your comment and support of the evidence base. We understand this is a difficult decision for people with type 2 diabetes and will require a large adaptation in behaviour. Highlighting the benefits and risks is important and helping the person to make an informed decision. For an SGLT-2 inhibitor and metformin: highlighting that if they take less medicine now then 123 out of 1,000 people in a similar situation will die, have a heart attack or a stroke over the next 3 years and 54 out of 1,000 people will be hospitalised with heart failure. If they do take it then they will have to take 3 tablets a day and for people in this situation the risk of dying, having a heart attack or a stroke reduces to between 107 to 115 people out of 1,000, while the risk of being hospitalised with heart failure reduces to 26 to 40 people out of 1,000 over 3 years. There is a very small increased risk of serious adverse events like diabetic ketoacidosis (between 1 in 1,000 to fewer than 1 in 1,000) but the risk can be reduced by ensuring they still hydrated. There is also a risk of serious genital infections, like

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					Fournier's gangrene, which is as rare, and milder genital infections (between 10 and 100 in 1,000), but it will reduce the chance of them dying, having a heart attack, a stroke or being hospitalised for heart failure over the next 3 years which are likely to have large, long term impacts on their quality of life.
NHS South East London ICB	Guideline	General		There are a number of places where GLP-1 analogues are recommended regardless of baseline BMI. Are there any recommendations from NICE on what BMI would be not appropriate for initiation or titration?	Thank you for your comment. The BNF states the side effects of decreased appetite and decreased weight for GLP-1 receptor agonists. Therefore, these side effects should be taken into consideration when assessing a person's requirements and decided if it is an appropriate medicine or not (for example a person living with underweight). The committee have made a recommendation in the "Reviewing other medicines" section to recommend stopping GLP-1 receptor agonists or tirzepatide if the person taking it becomes underweight (BMI under 18.5 kg/m ²).
NHS South East London ICB	Guideline	General		We note a prominent role of pioglitazone in the guideline lower down the algorithm. Use in practice is limited due to the side effect profile. It may be helpful to have a patient decision aid around the risks versus benefits.	Thank you for your comment. Pioglitazone is at the bottom of the pathway with every other agent that has limited evidence for anything but glycaemic benefit. Healthcare professionals are expected to have knowledge of the adverse events of the treatments they are prescribing. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine,

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					the British National Formulary (BNF) or British National Formulary for Children (BNFC). We agree that there is value in a patient decision aid in this area. NICE is considering developing a clinician discussion aid to help support implementation of this.
NHS South East London ICB	Guideline	General		Implementation of the draft recommendations in line with the evidence base, most notably wider access to GLP-1 analogues will have significant cost implications for the NHS. Central NHS budgets will need to factor in these costs from the outset and ensure these budgets are transferred to payers. It would be helpful to have more detailed information on outcomes, specifically patient outcomes and translation to health and social care cost savings in addition.	Thank you for your comment. Please see the evidence review documents and resource impact documentation for further information about the outcomes.
NHS South East London ICB	Guideline	002	008-018	We would recommend considering the results of the FLOW trial in recommendations which showed a reduction in major kidney disease events, a composite of the onset of kidney failure, at least 50% reduction in the eGFR from baseline or death from kidney related or CV events.	Thank you for your comment. The FLOW trial was included in the guideline. The composite outcome mentioned was not a prespecified outcome in the protocol but was considered qualitatively by the committee alongside the benefits that were prespecified in the guideline. When the health economic analysis was conducted, semaglutide was not cost-effective for people with chronic kidney disease. When weighing up the benefits against the cost effectiveness evidence, they agreed that there was insufficient evidence and that the cost and resource impact would be too great to make a recommendation in this update. Therefore, the committee agreed that semaglutide should not be recommended for people with chronic kidney disease at this time.

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NHS South East London ICB	Visual summary	002		We welcome recommendations based on patient factors however it is likely for a number of people living with diabetes that they will have multiple long term conditions e.g. chronic kidney disease and obesity. It would be helpful to reflect this in the visual summaries	Thank you for your comment and for your assessment of the clinical realities of type 2 diabetes. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it was most important to make recommendations based on the evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. However the committee agree with your assessment of multiple comorbidities. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to advise people to account for: a) medicines required for cardiovascular and renal protection, b) medicines that are contraindicated, c) medicines optimisation especially for people with frailty. Further information can be found in the committee discussion document.

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NHS South East London ICB	Guideline	019	004-009	Point 1.8.15 :People with Atherosclerotic Cardiovascular disease and use of semaglutide - Clearer guidance from NICE on HbA1c and BMI thresholds for initiating and titrating injectable semaglutide in this patient group would be beneficial to support consistent clinical decision-making.	Thank you for your comment. There is no BMI threshold for starting GLP-1 receptor agonists in this group. Subcutaneous semaglutide is being recommended for cardiovascular and renal protection as well as glycaemic benefits. This wording has been added to the recommendation.
NHS South East London ICB	Guideline and visual summary	019	013-015	1.8.17: This recommendation may imply that we are offering semaglutide in all patients with T2DM and cardiovascular disease. In those with raised BMI many will be prescribed Mounjaro or want/expect this given the HbA1c and weight reductions seen in trials and practice. Have other cardiovascular outcome trials been considered e.g. SURPASS CVOT?	Thank you for your comment. We could not assess the SURPASS-CVOT trial, as we did not receive sufficient evidence to support assessment of the clinical effectiveness of tirzepatide. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection. Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic benefits and potential positive side effect of weight reduction for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather than tirzepatide for people with atherosclerotic cardiovascular disease at this time.
NHS South East London ICB	Guideline and visual summary	027	002-008	1.8.47: We recognise this recommendation is based on the STEP-HFpEF trial. Many patients may want to consider Mounjaro. Has the evidence from the SUMMIT trial been considered?	Thank you for your comment. The SUMMIT trial discusses tirzepatide for people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the population criteria to be included in the guideline update.

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NHS South East London ICB	Guideline and visual summary	029	011-016	1.8.54: The guideline and algorithm states "GLP-1 RA" but the update section says "Semaglutide" - many will be prescribed Mounjaro or want this given the HbA1c and weight reductions seen in trials and practice.	Thank you for your comment. The update section has been updated. The recommendation has now been updated to include GLP-1 receptor agonist or tirzepatide.
NHS South East London ICB - Clinical Effectiveness Southeast London	Visual summary	002		This is fantastic and will really help on the ground clinicians with steps beyond metformin and SGLT2i.	Thank you for your comment. We appreciate your feedback.
NHS South East London ICB - Clinical Effectiveness Southeast London	Visual summary	002		Different wording is used: offer/add/consider – is this intentional? This is confusing.	Thank you for your comment. Some recommendations are made with more certainty than others. In NICE style, where there is strong evidence of benefit and cost-effectiveness, we use the terms 'offer' or 'add'. Where there is less certainty of benefit or cost-effectiveness NICE uses the terms 'consider' or 'consider adding'.
NHS South East London ICB - Clinical Effectiveness Southeast London	Visual summary	002		I wonder if the reformat of the document would strengthen the importance for most patients to be offered metformin and SGLT2i (which not everybody is doing yet), reduce some of the duplication in the existing draft and support a step wise approach to management which may help guidance acceptability and uptake. For example: Metformin for everyone unless CI/not tolerated – across all conditions	Thank you for your comment. We believe that the layout of the visual summary gives clarity for the healthcare professionals on the therapeutic options best suited for the individual. For example, specific SGLT-2 inhibitors are recommended for people with CKD whilst subcutaneous semaglutide is recommended as initial therapy alongside metformin and SGLT-2 inhibitors for people with atherosclerotic cardiovascular disease. Therefore we believe the information is more easily accessed by having individual columns for each comorbidity at the top of the page

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				SGLT2i for everyone - unless CI/not tolerates/frailty risk – across all conditions Then break into different conditions – this would strengthen the message for the need for both these drugs in most patients	
NHS South East London ICB - Clinical Effectiveness Southeast London	Visual summary	002	Semaglutide and GLP-1 content	For CVD states offer subcutaneous semaglutide. For other conditions it states consider adding/offer GLP-1 receptor agonist – not stating of the po or sc preparation should be used. If stating sc for semaglutide, please be clear if SC or e.g. po for the other GLP-1 content.	Thank you for your comment. For people with CVD, subcutaneous semaglutide has been specifically recommended based on the evidence. Where the guideline has not specified the route of administration, this has not been explicitly specified to keep the recommendations and the visual summary more succinct.
NHS South East London ICB - Clinical Effectiveness Southeast London	Visual summary	002	SGLT2i content	Will there be a change in suggested SGLT2i now that dapagliflozin has a generic option? Clinicians value a clear steer on type when possible different indications of different SGLT2i adds to confusion and may impact on uptake of guidance/as.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all

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					NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS South West London ICB	Guideline	General	General	There needs to be clarity around classes especially around GLP1s and Tirzepatide. There is no specific mention of the latter in this guidance or reference to NICE TA 924 and hence unclear if NICE considers tirzepatide as a GLP1 agent or does the GLP/GIP drugs (more to come on the market) feature as a class of their own? Potentially some positive CV outcomes data for Tirzepatide and wonder whether this will be/can be considered.	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist or tirzepatide", which is now used in the guideline where appropriate, to reflect where this includes tirzepatide. 'GLP-1 receptor agonist' alone is used when this only refers to GLP-1 mono-receptor agonists. There was no additional data identified that showed benefits for tirzepatide in providing protection from cardiovascular outcomes as current trials have not provided full manuscripts towards the work for this guideline.
NHS South West London ICB	Guideline	General	General	GLP1s: clarification needed on if wrap-around care will be offered. If not going to include full wrap around care then need to include education regarding muscle preservation diet in addition to healthy living advice	Thank you for your comment. Diet and exercise were outside of the scope for this update and so this has not been commented on. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.

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NHS South West London ICB	Guideline	023	018	Suggest consideration of a comment to be included that to minimise risk of DKA to NOT initiate SGLT2s if HbA1C significantly high (e.g. >84). This is common practice amongst specialists, but with the new guidance advocating for earlier and wider use of SGLT2s then it is likely to increase initiation in primary care generalists and so adding this assists with safety netting.	Thank you for your comment. We agree this is a really important area given the wider prescribing of the medicine. The committee acknowledged that while a high baseline HbA1c can be a concern for starting an SGLT-2 inhibitor, it was not an absolute contraindication, and each case should be considered on a case-by-case basis. They felt it was more important to take into account other modifiable risk factors than providing a specific HbA1c threshold at which SGLT2 inhibitors should be avoided. They ultimately agreed that the concern in this scenario is more about managing the causes of the adverse events, such as dehydration and volume depletion, that can increase the risk of events such as diabetic ketoacidosis; the recommendation on preventing DKA when taking SGLT2 inhibitors has been updated to reflect this.
NHS South West London ICB	Guideline	025	010	Suggest as above adding a safety netting recommendation that if continuing SGTL2 for renal and cardio protective benefits even if glycaemic control not achieved, then need to add a note that continuing where HbA1c is >84 mmol/mol increases risk of DKA and so temporarily stopping until HbA1c is reduced recommended.	Thank you for your comment. We agree this is a really important area given the wider prescribing of the medicine. The committee considered adding advice about SGLT-2 inhibitors and people with high baseline glucose levels. They ultimately agreed that the problem in this scenario is more about managing the causes of the adverse events, such as dehydration and volume depletion, that can increase the risk of events such as diabetic ketoacidosis. Given this they updated the recommendations in the section about "Preventing diabetic ketoacidosis when taking SGLT-2 inhibitors" to give warning about this. They acknowledged that while a high baseline HbA1c can be a concern for starting an SGLT-2 inhibitor, it was not an absolute contraindication, and each case should be considered on a case by case basis.

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NHS South Yorkshire ICB	Guideline	General		Make clear within guideline that when referring to GLP-1RA does this include tirzepatide or not?	Thank you for your comment. The terminology has been changed to "GLP-1 receptor agonists or tirzepatide" to make it clear where the place for tirzepatide is in the guideline.
NHS South Yorkshire ICB	Guideline	General	al	When making recommendations around using a class of drug, state to use the drug in class with the lowest acquisition unless clinical reasons for not doing so.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).

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NHS South Yorkshire ICB	Guideline	013	010	Recommendation 1.8.1 Consider effectiveness on wt loss in those who are overweight or obese	Thank you for your comment. The committee have now included the effect of each medicine on weight in this recommendation.
NHS South Yorkshire ICB	Guideline	013	015	Recommendation 1.8.2 Hyperlink to obesity	Thank you for your comment. The sections on initial medicines and treatment options if further medicines are needed for people living with obesity now include cross-references to recommendations on classifying overweight and obesity in NICE's guideline on overweight and obesity management.
NHS South Yorkshire ICB	Guideline	013	020	Recommendation 1.8.2 reference pregnancy at this point and link to MHRA What considerations are need with regards other antidiabetic drugs in pregnancy.	Thank you for your comment. This recommendation has been added following an MHRA warning. For guidance about other medicines, the box at the start of the "Initial medicines" and "Treatment options if further medicines are needed" sections provides guidance to refer to the summary of product characteristics for that individual medicine to check.
NHS South Yorkshire ICB	Guideline	016	007-016	Recommendation 1.8.6 - More clarity as to who agrees these rules with patient and training for clinicians on this. Give more specific recommendations with regards sick day rules. Time is needed for clinicians to develop plans and counsel patients with sick day rules and this could have a significant impact on workload.	Thank you for your comment. We have not identified a specific person as we believe that everyone involved in managing medicines has a responsibility to ensure that these rules are in place. We acknowledge that this could have a significant impact but also that if people develop complications from diabetic ketoacidosis from continuing treatments that put them at risk of volume depletion (such as SGLT-2 inhibitors), hypoglycaemia (from incorrect insulin management) and acute kidney injury that there will be worse outcomes to people with diabetes and much larger costs to healthcare professionals and resources. Therefore, we believe that this is important for all people in hospital.

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NHS South Yorkshire ICB	Guideline	017	002	Recommendation 1.8.7- Should weight and age (life time risk) be part of the assessment	Thank you for your comment. A formal assessment of cardiovascular risk would include an assessment of lifetime risk based on a full formal risk assessment. Relevant tools take into account age and weight.
NHS South Yorkshire ICB	Guideline	017	010	Recommendation 1.8.8- Visual summary is helpful	Thank you for your comment.
NHS South Yorkshire ICB	Guideline	018	005	Recommendation 1.8.10- Consider changing wording to use the metformin formulation with the lowest acquisition cost making reasonable adjustments where necessary	Thank you for your comment. Following further consideration of the variability of cost against the benefits to people with type 2 diabetes, this has been changed to recommend modified release metformin first line instead.
NHS South Yorkshire ICB	Guideline	018	015	Recommendation 1.8.13-As above	Thank you for your comment. The current UK marketing authorisations for SGLT-2 inhibitors are for the treatment of adults with type 2 diabetes mellitus (T2DM). Heart failure is not a separately licensed indication in section 4.1 of the SmPC. However, section 5.1 of the SmPC includes data on heart failure outcomes, reflecting the regulatory assessment that these results are consistent with, and supportive of, the overall benefit–risk profile of SGLT2 inhibitors in T2DM. Therefore, it is appropriate to consider the benefits on heart failure outcomes within the scope of the approved indication when evaluating SGLT2. Given this, the committee agreed that a class based recommendation was appropriate in this circumstance.
NHS South Yorkshire ICB	Guideline	019	009	Recommendation 1.8.15-Make reference to TAs for obesity and interdependencies with this recommendation and advice on which GLP-1 RA to use when patient is overwt/ obese in this cohort of	Thank you for your comment. The medicines being discussed in this guidance are primarily for the management of cardiovascular and renal risk and glycaemic benefit (while acknowledging they will also provide weight management

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				patients. Advice re what clinician should consider – e.g. If pt obese should semaglutide be up titrated if HbA1c controlled but wt loose still beneficial? or switch to tirzepatide if in cohort eligible for obesity? As better wt loss (but is this clinically significant?) This area will cause a lot of confusion. over 90% of cohort 1 who are eligible for tirzepatide for wt loss are T2DM, so primary care clinicians will need clear advice on this issue.	benefits). If the goal is primarily for weight management then people are recommended to refer to the obesity and overweight management guideline, which is cross referred to in the guideline.
NHS South Yorkshire ICB	Guideline	020	005	Recommendation 1.8.18-Does weight have an implication with regards the decision to start GLP-1 RA. Also which GLP1 agonist? Lowest acquisition? Is tirzepatide (which is a GIP and GLP1 agonist included in this recommendation?)	Thank you for your comment. The committee agreed that starting weight is generally not important in the decision to start GLP-1 receptor agonists or tirzepatide and have not stated a BMI threshold for this decision. They have made a recommendation for reviewing treatment that GLP-1 receptor agonists or tirzepatide should be stopped if the person becomes underweight. There is no preference on which GLP-1 receptor agonist or tirzepatide in this group. We have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor

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					agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin). The term "GLP-1 receptor agonist" has been changed to "GLP-1 receptor agonist or tirzepatide" to include tirzepatide.
NHS South Yorkshire ICB	Guideline	020	014-015	Recommendation 1.8.21-Where does use of GLP-1 RA sit in this cohort and can you cross reference the TAs.	Thank you for your comment. There are no technology appraisals for GLP-1 receptor agonists for people with type 2 diabetes. There are technology appraisals for GLP-1 receptor agonists and tirzepatide for people living with obesity (who may or may not have type 2 diabetes). We have cross referred to NICE's guideline on overweight and obesity management which discusses this in detail in the section discussing "Treatment options if further medicines are required" where GLP-1 receptor agonists or tirzepatide are considered for people with type 2 diabetes who are living with obesity.
NHS South Yorkshire ICB	Guideline	021	010	Recommendation 1.8.24-Add in statement around use drug with lowest acquisition cost as dapagliflozin is currently more cost-effective	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to

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					recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS South Yorkshire ICB	Guideline	022	002	Recommendation 1.8.27-Recommend specific DPP4 inhibitor as not all can be used with eGFR<20, ro state, not not all DPP4 can be used - refer to individual SPC.	Thank you for your comment. Although the BNF states that caution should be used when prescribing sitagliptin and saxagliptin for people with an eGFR less than 45 ml/min/1.73 m ² , and that caution should also be used when prescribing alogliptin and vildagliptin to people with a creatine clearance

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					less than 50 ml/min, these treatments can still be used when their dose is reduced to that specified in the BNF. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
NHS South Yorkshire ICB	Guideline	022	007	Recommendation 1.8.33-Clarify statement about introduce on stepwise manner as this is conflicting with advice to start meds at same time, inferring no need to start sequentially.	Thank you for your comment. The recommendation to introduce medicines in a stepwise manner should be used in conjunction with recommendations about initial medicines for each population. Although the recommendations may state that people should receive dual or triple therapy, these medicines should still be introduced in a stepwise manner.
NHS South Yorkshire ICB	Guideline	025	007-021	Recommendations 1.8.41 to 1.8.45-Consider making reference to reviewing and stopping in frailty	Thank you for your comment. The guideline includes a recommendation around reviewing the person's overall diabetes treatment plan for people with frailty in the section for initial medicines for people with frailty. This is also discussed in NICE's guideline on medicines optimisation and multimorbidity, which are referenced in this guideline.

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NHS South Yorkshire ICB	Guideline	027	002	Recommendation 1.8.47-Why is subcutaneous semaglutide recommended and not tirzepatide, which can be used under the wt management pathways in primary care. Can you cover the reasons why in the explanation?	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed the recommendation for subcutaneous semaglutide in this population given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management. The SUMMIT trial includes people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update. This means there is no evidence to show that tirzepatide is clinically or cost-effective for this population.
NHS South Yorkshire ICB	Guideline	028	002-004	Recommendation 1.8.49-Why is subcutaneous semaglutide recommended and not tirzepatide, which can be used under the wt management pathways in primary care. Can you cover the reasons why in the explanation?	Thank you for your comment. While we have seen the initial findings from the SURPASS CVOT trial, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection while GLP-1 receptor agonists included in the review have shown this and

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					subcutaneous semaglutide has shown this and cost-effectiveness, therefore being recommended.
NHS South Yorkshire ICB	Guideline	028	013-015	Recommendation 1.8.18 already recommends a GLP-1 RA is considered in early onset. Make reference to this.	Thank you for your comment. Recommendation 1.8.18 in the consultation document relates to initial treatment of type 2 diabetes whereas Recommendation 1.8.51 in the consultation document refers to reconsidering the addition of a GLP-1 receptor agonist or tirzepatide for those not reaching their individualised glycaemic target who did not receive it as part of their initial therapy.
NHS South Yorkshire ICB	Guideline	029	011-021	This section needs to make better reference to the obesity TAs and which pathway should be prioritised.	Thank you for your comment. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this.
NHS South Yorkshire ICB	Guideline	030	013-016	Can you also reference the TA for obesity.	Thank you for your comment. A new recommendation has been added to reference NICE's guideline on overweight and obesity management, which discusses all of the technology appraisals for people where weight management is their primary goal.

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NHS South Yorkshire ICB	Guideline	032	001-003	Can you link to when CGM or BGT is cost effective in these pts	Thank you for your comment. CGM and BGT is out of scope for this guideline update.
NHS South Yorkshire ICB	Guideline	035	001-005	This sentence is helpful.	Thank you for your comment.
NHS South Yorkshire ICB	Guideline	052	020	Disagree that starting metformin and SGLT2I (and GLP1 in relevant cohorts, i.e. those with atherosclerotic CVD) will not lead to more appointments. If these are being started in all pts sequentially then this will take time to optimise. Also More details needed around what sequentially means and suggestion that more put into QoF to drive this and reward practices financially for the extra appointments.	Thank you for your comment. We have adjusted the wording to reflect that these changes may result in an increase in the number of appointments. Additional detail has been added to the rationale regarding adding the SGLT-2 inhibitor once metformin at maximum achievable dose is established.
NHS Surrey Heartlands ICB	Consultation questions		001	Implementation challenge: Affordability and Commissioning Expanding access to SGLT-2 and GLP-1 therapies at this scale will require robust national commissioning guidance and linked funding plans to avoid inequitable rollout between systems	Thank you for your comment. Your feedback will be considered by NICE where relevant support activity is being planned.
NHS Surrey Heartlands ICB	Consultation questions		001	Implementation challenge: Workforce and Training Delivering structured education on insulin initiation, self-management, and sick day rules will require additional workforce capacity across primary and community care. NICE should consider supporting digital and hybrid education models.	Thank you for your comment. Your feedback will be considered by NICE where relevant support activity is being planned.

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NHS Surrey Heartlands ICB	Consultation questions		001	Implementation challenge: Complex Treatment Pathways The expanded algorithms are evidence-based but risk being difficult to operationalise in busy clinical practice . Integration of decision-support tools within electronic health records (locally we use Ardens in our EPR) would support safe and consistent implementation.	Thank you for your comment. Your feedback will be considered by NICE where relevant implementation support activity is being planned.
NHS Surrey Heartlands ICB	Consultation questions		001	Implementation challenge: CGM Access Without national procurement models , there is a risk of postcode variation. Training for primary care teams in interpreting CGM data is also critical for safe use.	Thank you for your comment. Access to continuous glucose monitoring was outside the scope of the type 2 diabetes medicines update.
NHS Surrey Heartlands ICB	Guideline	General		Across our clinical network we welcome this updated guideline, which reflects advances in evidence and practice since NG28 (2015) and in particular: - the emphasis on personalised, comorbidity-driven care - alignment with remission programmes the prioritisation of cardiovascular, renal, and metabolic outcomes in treatment choices.	Thank you for your comment. We appreciate your feedback
NHS Surrey Heartlands ICB	Guideline	General		First-line combination therapy with Metformin and SGLT-2 inhibitors reflects best current evidence, is already influencing practice locally, and helps reduce clinical inertia	Thank you for your comment. We appreciate your feedback

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NHS Surrey Heartlands ICB	Guideline	General		The prioritisation of GLP-1 receptor agonists for people with ASCVD, obesity, or early-onset diabetes represents an important step towards addressing long-term outcomes beyond glycaemic control	Thank you for your comment. We appreciate your feedback
NHS Surrey Heartlands ICB	Guideline	General		A frailty-sensitive approach is welcome, reducing overtreatment and minimising harm in older and multi-morbid populations	Thank you for your comment. We appreciate your feedback
NHS Surrey Heartlands ICB	Guideline	General		Stronger alignment is needed with local weight management and remission services , such as the NHS Type 2 Diabetes Path to Remission programme. Uptake has been limited in some areas because of the additional non-GMS workload required in primary care.	Thank you for your comment. This area is out of scope of the guideline update. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
NHS Surrey Heartlands ICB	Guideline	General		NICE should reinforce the importance of an equity lens , ensuring access for people in deprived communities, those with limited digital or health literacy, and ethnically diverse groups most affected by diabetes complications.	Thank you for your comment. We agree and have taken this into account in this guideline update and have made a research recommendation to support this. We have added a recommendation to aid the implementation of increased SGLT-2 inhibitor use.
NHS Surrey Heartlands ICB	Guideline	General		Wider adoption of digital structured education would improve accessibility and uptake across Surrey Heartlands and nationally	Thank you for your comment. This is outside of the scope of the guideline update.
NHS Surrey Heartlands ICB	Resource impact template	Events avoided		We don't believe that anyone will have better information so consider locking these cells	Thank you for your comment.

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NHS Surrey Heartlands ICB	Resource impact template	Inputs and population	E45, E56, E68	Future market share. Can it be stated how far in the future? Assume 3 years from further tabs but not stated	Thank you for your comment. This has been updated to state Year 3.
NHS Surrey Heartlands ICB	Resource impact template	Inputs and population	E48	Can NICE give a potential future % market share of generic dapagliflozin (which can be amended locally if needed)	Thank you for your comment. We are unable to include this data as it is not currently available. Users can amend the potential future % market share of generic dapagliflozin to reflect local assumptions.
NHS Surrey Heartlands ICB	Resource impact template	Inputs and population	H45, H56, H68	Future number of people. Can it be stated how far in the future? Assume 3 years from further tabs but not stated	Thank you for your comment. This has been updated to state Year 3.
NHS Surrey Heartlands ICB	Resource impact template	Prevalence of diabetes by ICB	B43	Potential error: Using NHS Surrey Heartlands for example, this is 71,135 on the 'Inputs and population' tab. Is this meant to relate to the figure on the previous tab, which for NHS Surrey Heartlands is 57,936?	Thank you for your comment. The 71,135 is applying the national prevalence of diabetes for the NHS Surrey Heartlands population. If the prevalence of diabetes 2024/25 (per prescribing diabetes) data is more accurate you can replace the 71,135 with 57,936.
NHS Surrey Heartlands ICB	Visual summary	ASCD		The statement in the ASCD box about suitability of medicines in patients with other co-morbidities would presumably apply to all the co-morbidities included in the flowchart. Should this statement therefore be separated out from just ASCD?	Thank you for your comment. This statement is made here as it is linking other comorbidities to the atherosclerotic cardiovascular disease stem and states 'pioglitazone' while including people with heart failure in the same box, which could lead to prescribing problems. While we agree this applies overall, we consider this assumed knowledge but want it to be explicit in this section due to the obvious contradiction in this case.
NHS Surrey Heartlands ICB	Visual summary	General		To further support implementation and alert prescribers, it would be useful if the flowchart also	Thank you for your comment. The visual summary has been updated to make it clear that drugs are to be initiated sequentially.

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				included an additional box about introducing the initial drugs sequentially	
NHS Surrey Heartlands ICB	Guideline	016	006	The clearer guidance on sick day rules is essential for patient safety. Like other regions, we have seen avoidable acute admissions with AKI when this advice has not been followed.	Thank you for your comment. We are reassured that this is an important area that has been covered in the guidance.
NHS Surrey Heartlands ICB	Guideline	025	013	The inclusion of discontinuation criteria is very welcome, but further clarity is needed on responsibility for monitoring (primary vs secondary care) and the appropriate review intervals . Also clarity with regards to dose titration for patients that have met their agreed goals but wish to lose more weight. These patients would not currently meet the national phase 1 cohorts for weight management if they only have diabetes as a co-morbidity which does introduce some inequity.	Thank you for your comment. In terms of responsibility for monitoring (primary vs secondary care) , it doesn't lie with one person as medicines optimisation is the responsibility of all involved in managing treatment. But we believe these treatments can be initiated in primary care for most people so monitoring can take place in primary care. We have not evaluated evidence on timings for reviews as this was outside the scope and so we are not able to comment on the optimal review interval. This can be individualised and directed by the needs of the person in alignment with evaluations for other parts of their care. In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the

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					relevant technology appraisals. Edits have been made to the guideline to reinforce this.
NHS Surrey Heartlands ICB	Guideline	039		The explicit focus on equity of access to CGM is vital, as uptake is lowest in groups at highest risk of poor outcomes	Thank you for your comment. CGM is out of scope for this guideline update.
NHS Sussex ICB	EHIA	General		Given the committee were presented with real world evidence that showed that SGLT-2 inhibitors are under-prescribed, particularly to women and older people, and to people from some ethnic backgrounds should this be woven throughout the guideline? There is a section on early onset type 2 diabetes, is there the opportunity to highlight health inequalities? Additionally, given there are specific recommendations for CGM monitoring (1.7.26) "Commissioners, providers and healthcare professionals should address inequalities in CGM access and uptake by monitoring who is using CGM, identifying groups who are eligible but who have a lower uptake, making plans to engage with these groups to encourage them to consider CGM", is there the opportunity to consider similar recommendations for SGLT2i monitoring given the EHIA and SGLT2i uptake report?	Thank you for your comment. The committee was in agreement with your suggestion. We have added a recommendation to capture this in the section 'Addressing inequalities in use of SGLT-2 inhibitors'.

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NHS Sussex ICB	Guideline	General		Does there need to be a section on non-diabetes medication cardiovascular/renal protection i.e ACEi/ARB in event of raised microalbuminuria.	Thank you for your comment. Non-diabetes medication is outside the scope for this guideline, so we have not included a section on it. If this needs to be considered then there are references to the guidelines for cardiovascular disease: risk assessment and reduction, hypertension and chronic kidney disease included in the guideline which can support healthcare professionals to make decisions in these areas.
NHS Sussex ICB	Health economic analysis			Tirzepatide is not considered in the economic analysis. Exenatide has been discontinued in the UK but has been included in the economic analysis.	Thank you for your comment. The committee reviewed the evidence for the cost-effectiveness of tirzepatide for managing type 2 diabetes, as outlined in NICE TA924. The committee amended their recommendations to include tirzepatide wherever the class of GLP-1 receptor agonists are recommended. Exenatide has been removed from the analysis.
NHS Sussex ICB	Resource impact template	General		The resource impact tool gives modelling for GLP-1 RAs for ASCVD and early onset. Is there modelling for impact in obesity?	Thank you for your comment. We have focused our workings on the initial treatments where significant resource impact is expected. The recommendation for GLP-1 receptor agonists for those with obesity are consider recommendations when further treatment may be needed.
NHS Sussex ICB	Visual summary	General		States "at each point reinforce advice about diet and behaviour change"- opportunity to include healthy living	Thank you for your comment. This has now been changed to diet and healthy living.
NHS Sussex ICB	Visual summary	General		The algorithm implies offering agents together, however the guideline states to confirm tolerability before introducing the next agent, this may lead to confusion if not read in conjunction	Thank you for your comment. The visual summary has been updated to make it clear that drugs are to be initiated sequentially.

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NHS Sussex ICB	Visual summary	General		There is a concern that the first column 'no relevant comorbidities' downplays people who are at high risk of CVD and therefore should be offered an SGLT2i with proven cardiovascular benefit.	Thank you for your comment. The committee agree that it is very unlikely that anyone with type 2 diabetes is actually at low cardiovascular risk, and this has been highlighted in the rationale for Initial medicines: People with type 2 diabetes and no relevant comorbidities. The title of 'no relevant comorbidities' just shows the treatment that people should be offered if they do not have obesity, chronic kidney disease, early onset type 2 diabetes, heart failure, atherosclerotic cardiovascular disease and frailty. The committee chose not to state SGLT-2 inhibitor with a proven cardiovascular benefit because they agreed that all the drugs in this class have cardiovascular benefits.
NHS Sussex ICB	Visual summary	General		Under the column CKD, it recommends offering metformin but does not mention dose reduction might be needed depending on renal function	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. Further information can be found in the committee discussion for details on dose reduction with metformin under the section "People with chronic kidney disease and initial therapy: when can metformin and SGLT-2 inhibitor therapy be given?" and in the "Rationale and Impact" section of the guideline.
NHS Sussex ICB	Visual summary	General		Under the column CKD, there is no reference to the pt being on maximum tolerated dose of ACEi or ARB	Thank you for your comment. Previous recommendations relating to this have been removed for this update because people with chronic kidney disease who are eligible for an SGLT-2 inhibitor (with an eGFR of 20 ml/min/1.73 m ² and above) are discussed in the new medicines recommendations. Stating the maximum tolerated dose of ACEi or ARB is outside

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					the scope of this guideline. Please refer to NICEs information on prescribing medicines .
NHS Sussex ICB	Visual summary	General		Under column CKD, is there the opportunity to mention that glucose lowering effect is reduced if eGFR <45mls/min and other agents may need to be considered in addition	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact sections of the guideline. Additional information can be found in the committee discussion under the session "People with chronic kidney disease: distinction between stages" for the committee's reasoning in not using an eGFR of 45mls/min/1.73m ² .
NHS Sussex ICB	Visual summary	General		Tirzepatide is not included within the algorithm, however it is referenced in the guideline: "Tirzepatide is recommended as an option in NICE technology appraisal guidance for some adults with type 2 diabetes when it is insufficiently controlled". There is a concern that this may lead to variation in prescribing.	Thank you for your comment. Tirzepatide has now been included in the guideline in relevant places (see recommendations including "GLP-1 receptor agonists or tirzepatide").
NHS Sussex ICB	Visual summary	General		Under the obesity column, the algorithm however states: "Consider adding a GLP-1 receptor agonist" but does not reference specific medications within the class based on weight loss efficacy. Table 1 within the guidance (page 92) refers to "consider	Thank you for your comment. This error in Table 1 on page 92 has now been amended. The committee agreed that no GLP-1 receptor agonist should be specified. While liraglutide came out as cost-effective in one sensitivity analysis, the committee agreed that it did not show

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				adding semaglutide for adults with type 2 diabetes who are living with obesity”. Additionally, noting the evidence showed that no GLP-1 receptor agonist reached the cost effectiveness threshold in the base-case analysis for people living with obesity but when price of liraglutide reduced by 35% was used in the sensitivity analyses, there was potential for GLP-1 receptor agonists to be cost effective under specific circumstances should this be considered, should reference be made.	evidence of clinically important reductions in weight loss and the evidence for cardiovascular and renal protection and glycaemic benefits was stronger with other GLP-1 receptor agonists. Given this, they did not want to make a specific recommendation and agreed it was more appropriate to provide flexibility in this case
NHS Sussex ICB	Guideline	018-020	004	The recommendation for SGLT2i alongside metformin in early onset Type 2 diabetes for all, particularly those with low cardiovascular risk is not evidence based. While the lifetime risk of cardiovascular disease is high in those with early onset diabetes, in the first 5 years post-diagnosis this may be outweighed by the increased risk of genital tract infections and DKA (see e.g. Multiple Comparison SoF). This could be mentioned in the text, as well as risk for potential pregnancy. A worry that younger, particularly women, get this as standard, develop infection problems that potentially precludes use at an age of higher cardiovascular risk. This needs to be balanced	Thank you for your comment. The committee considered evidence of the high lifetime risk of cardiovascular disease in this population and agreed that in order to reduce the risk of this, early treatment was required. We acknowledge the increased risk of adverse events. However, when balanced against the benefits we agreed that the benefits outweigh the potential harms. Benefits were seen in reducing the number of people dying from cardiovascular disease, having a heart attack or a stroke (3-item MACE) and hospitalisation for heart failure. 123 out of 1000 people have a 3-item MACE event over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by 8 to 16 people if an SGLT-2 inhibitor is used for 3 years. Meanwhile, 54 out of 1000 people are hospitalised with heart failure over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by

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				against the knowledge that early aggressive treatment has a long-lasting legacy.	14 to 28 people if an SGLT-2 inhibitor is used for 3 years. These clinically important reductions were weighed against the chance that 10 to 100 in 1000 people would experience genital infections and 1 in 1000 to 1 in 10,000 people would experience rarer events like diabetic ketoacidosis or Fournier's gangrene or severe infections. Given this, the committee agreed that in most cases the benefits outweighed the risks. They agreed that the risk of volume depletion is manageable, and that it would be uncommon for it to lead to diabetic ketoacidosis. They noted that these risks should be discussed with the person ahead of starting treatment. Furthermore, the committee agreed the benefits to reducing inequalities in providing SGLT-2 inhibitors and metformin as a part of standard therapy for most people with type 2 diabetes. Health inequalities have been highlighted that show that providing SGLT-2 inhibitors will provide net health benefits for people living in the lowest two quintiles of the index of multiple deprivation. By implementing this recommendation on a population level, where the default position is to provide the treatment and consider the exceptions where you should not, this will help to reduce health inequalities and ensure that the health of the whole population improves, reducing deaths,

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					cardiovascular events, renal disease and glycaemic complications. Taking this into account, we believe that providing the option to people with type 2 diabetes is important to allow them to make the decision about what they want. Additionally, it is difficult to draw comparisons between the work in this evidence review and the work conducted by Agarwal et al. 2025 due to differences in methodology used when conducting the reviews. This review uses similar evidence (as we worked in collaboration with some of the authors involved in this work through the ALIVE evidence collaboration) and the findings are generally in alignment, which is reassuring. The evidence supporting the living guideline was using the same odds ratios and evidence for each risk group, but likely changing the control group risk to emulate the risk in the different populations. This holds uncertainty as this may not accurately reflect the risk of the population in the trials (which are often higher risk populations) and so introduces confounding and limits applicability of the evidence. The findings appear to use the same evidence as was presented in Nong et al. 2025 where only one group was present, and appears similar to the evidence presented by the NICE review. We do not believe that this precludes them from accessing the treatment long term. We also acknowledge that they, by nature of type 2 diabetes, already have a higher cardiovascular risk – the reason for providing treatment is to reduce that so that we can keep that lower for longer.

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NHS Sussex ICB	Guideline	008	016	There is a section signposting to guidance for diagnosis and management of hypertension, but there is not a similar section hyperlipidaemia e.g. NG238	Thank you for your comment. This is out of scope for the guideline update.
NHS Sussex ICB	Guideline	013	026	Mentions rtCGM or isCGM – is it worth updating the guidance as most first line, cost-effective CGM is rt, and isCGM does not need to be mentioned as a separate entity.	Thank you for your comment. This section is out of scope for the guideline update.
NHS Sussex ICB	Guideline	015	010	It might be helpful to include a recommendation around cost if two drugs in the same class are appropriate, to choose the one with the lower acquisition cost	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this

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					case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS Sussex ICB	Guideline	015	018	Reference to GLP-1 RAs, but not dual GIP/GLP-1RA	Thank you for your comment. The committee have assessed the evidence and have agreed that tirzepatide should be included in the recommendation. Therefore, this has been amended to GLP-1 receptor agonists and tirzepatide.
NHS Sussex ICB	Guideline	015	018	Discusses GLP-1 receptor agonists in those of childbearing potential. Consider including this information under a separate heading or within the section "assessing risks before starting treatment" to improve flow and readability.	Thank you for your comment. We agree that this information is important. This was viewed as a part of conversation with the person while having a medicine discussion, which should always be considered, regardless of whether you are starting the medicine for the first time. Pregnancy, the chance to become pregnant and breast feeding are not a risk associated with type 2 diabetes while cardiovascular disease, worsening renal disease or frailty are and so are listed under 'Assessing risk before starting medicines' (as the latter is related to determining which treatment pathway to use when choosing medicines, while the former would either be offered the same treatment options or be considered in NICE's diabetes in pregnancy guideline). Therefore, we think this is in the right place currently. Thank you very much for your feedback.
NHS Sussex ICB	Guideline	019	005-009	We agree with the recommendation for subcutaneous semaglutide, however, there is evidence to suggest that liraglutide (via LEADER trial), dulaglutide (via REWIND trial) and tirzepatide	Thank you for your comment. Of the trials you mention, only the data from REWIND was included in the analysis for people with atherosclerotic cardiovascular disease (ASCVD). The data from LEADER was included in the analysis for people with

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				(via SURPASS-CVOT) also reduce ASCVD events. These should be recommended as an alternative for patients unable to tolerate semaglutide, to ensure prescribers are not discouraged from using GLP-1 receptor agonists where appropriate. Indeed, should tirzepatide be first choice with others as alternatives.	higher risk of CVD and people with heart failure, and not enough evidence was received for the SURPASS-CVOT trial to assess cardiovascular and renal benefits for tirzepatide in people with ASCVD. Therefore subcutaneous semaglutide was the only medicine out of the GLP-1 receptor agonists or tirzepatide that we received sufficient evidence to review that showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather than tirzepatide, liraglutide and dulaglutide for people with atherosclerotic cardiovascular disease at this time.
NHS Sussex ICB	Guideline	020	012	People living with obesity. Noting BMI criteria has been removed, should the term be defined within the "terms used in this guideline section" or as per the obesity guideline with reference to "healthy weight". There is a concern that not defining obesity may lead to variations in prescribing. The Tirzepatide TA references BMI.	Thank you for your comment. The sections on initial medicines and treatment options if further medicines are needed for people living with obesity now include cross-references to recommendations on classifying overweight and obesity in NICE's guideline on overweight and obesity management.
NHS Sussex ICB	Guideline	021	006	People with CKD. Within this section is there the opportunity to mention that glucose lowering effect is reduced if eGFR <45mls/min and other agents may need to be added in addition	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology

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					appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .
NHS Sussex ICB	Guideline	021	008-010	The CANVAS, CREDENCE and CAMPIONE studies demonstrated reduction in the progression rate of CKD in patients with type 2 diabetes and CKD and should be considered alongside empagliflozin and dapagliflozin in this cohort.	Thank you for your comment. CANVAS and CREDENCE trials were included in this review however CAMPIONE was excluded based on the comparator used in the trial (stated as guideline standard of care only). The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .
NHS Sussex ICB	Guideline	023	011	States to introduce the medicines one at a time, starting with metformin and checking tolerability. If using an SGLT-2 inhibitor, start this as soon as metformin tolerability is confirmed. We are concerned that this is not reflected in the algorithm which implies to start together.	Thank you for your comment. The therapy combinations for each population of interest are listed in sequential recommendations with all recommendations regarding introduction of medicines following this information. As all therapy combinations require a stepwise initiation, the recommendations for introducing medicines are listed in a way so as to avoid repetition of the same statements and to avoid confusion. We have added the wording "at the maximum achievable dose" to make it clear when the next medicine should be started. We have made amendments to the visual summary to make this message clear.
NHS Sussex ICB	Guideline	028	005	People with early onset type 2 diabetes. Recommends "for adults with early onset type 2 diabetes: Offer metformin and an SGLT-2 inhibitor. Consider adding a GLP-1 receptor agonist". Is there	Thank you for your comment. A recommendation in section Involving people in medicine discussions describes discussing GLP-1 receptor agonists with people of childbearing potential

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				the opportunity to expand to include consideration of childbearing potential (and link to guidance)	and refers to MHRA guidance on GLP-1 medicines for weight loss and diabetes
NHS Sussex ICB	Guideline	028	005	People with early onset type 2 diabetes. Opportunity to mention targeted education, T2DAY programme	Thank you for your comment. Targeted education is outside of the scope of this guideline update and so will not be discussed.
NHS Sussex ICB	Guideline	028	009	Given atherosclerotic cardiovascular benefit of pioglitazone, does the evidence really show that this is equivalent to SU/ insulin for those needing additional treatment? Given low acquisition cost where does it come with respect to GLP1/(GIP)? Obviously needs to be avoided in heart failure, and we need to be mindful of weight gain, osteoporosis and bladder risks.	Thank you for your comment. This recommendation lists medicines that can be prescribed for adults with T2DM with atherosclerotic cardiovascular diseases in whom initial treatments (metformin, SGLT-2 inhibitor and GLP-1 receptor agonists) have not been effective in reaching glycaemic targets. The committee agreed that pioglitazone is an option to manage HbA1c increases that do not respond to other treatments. While they noted the effects on cardiovascular benefits, they were not confident in the evidence of this and did not make a strong recommendation for it being used in this case, instead focussing on the glycaemic benefits. They thought this was appropriate especially given the risks for people with heart failure. Therefore, they recommended pioglitazone alongside other options for people who require further medicines to reach glycaemic targets. Please refer to the rationale and impact section and the committee discussion for more information.
NHS Sussex ICB	Guideline	029	011-016	We recommend rewording from 'consider adding' to 'offer' to reduce cardiovascular risk.	Thank you for your comment. We agree that GLP-1 receptor agonists will also provide cardiovascular and renal protection benefits in this case. However, the majority of GLP-1 receptor agonists were not cost effective leading to uncertainty in the

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					recommendation, which led to the consider adding recommendation, instead of an offer recommendation. The committee have recommended that any GLP-1 receptor agonist or tirzepatide can be considered for people in this population given that all available GLP-1 receptor agonists showed glycaemic benefits and some cardiovascular benefits. The most clinically effective was subcutaneous semaglutide which was slightly over the threshold for cost-effectiveness. On the other hand, liraglutide was cost effective but was less clinically effective. Other GLP-1 receptor agonists and formulations of GLP-1 receptor agonists (such as oral semaglutide) were not cost effective and were comparatively less clinically effective. Tirzepatide was shown to be cost effective in the technology appraisal for people with type 2 diabetes but did not have evidence for cardiovascular and renal benefits, which GLP-1 receptor agonists did have. This produced uncertainty in the evidence. Given this, they made a weaker consider recommendation in this case.
NHS Sussex ICB	Guideline	030	013	Tirzepatide being mentioned as an option, rather than as a core part of the guidance (particularly given its wide use) is a shame. We understand the timeline of producing guidance but this seems like a big omission.	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist and tirzepatide" to show the role of tirzepatide in this population.
NHS Sussex ICB	Guideline	033	004	Should there be reference to human basal insulin as first line (given the acquisition cost and the lack of evidence of increase benefit of analogue insulin	Thank you for your comment. This has been added in. The insulin recommendations have been updated in response to the withdrawal of insulin products and known brand shortages as discussed in the rationale. Given this, no specific insulin is

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				in people with Type 2 diabetes) be more explicit with mentioning choosing preparation types.	recommended, except where pre-mixed insulin preparations are discussed where pre-mixed human insulin preparations are recommended.
NHS Sussex ICB	Guideline	092		Within the table it states "consider adding semaglutide for adults with type 2 diabetes who are living with obesity, if: • they have been taking initial therapy for at least 3 months and • further medicines are needed to reach their glycaemic targets and • they are not already taking a GLP-1 receptor agonist. [2025] (1.8.54)". The algorithm however states: "Consider adding a GLP-1 receptor agonist"- should semaglutide be specifically referenced?	Thank you for your comment. Thank you for highlighting this, this has been amended.
NHS West Yorkshire ICB	Visual summary	001		Diet and lifestyle change advice – needs to be made more prominent and run through page 2 (medicines algorithm)	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
NHS West Yorkshire ICB	Visual summary	001		Under diet and lifestyle there is no reference to the remission programme, and the importance of aiming for remission within 6 years of diagnosis. We	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. However, we have added a

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				would suggest adding a line under 'diet and behaviour change'	recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline
NHS West Yorkshire ICB	Visual summary	001		It doesn't make clear whether to initiate standard release or modified release metformin in those naïve to treatment on page 2 (it is listed on page 1). We would suggest making this clearer on the algorithm on page 2 if possible.	Thank you for your comment. The guideline has been updated to change to recommending modified release metformin for most people. This change has been carried across to the visual summary.
NHS West Yorkshire ICB	Visual summary	002		Column 2 (Obesity) Green box 'Consider adding a GLP-1 receptor agonist if not already taking one and initial therapy started 3 months ago or more', please clarify if this excludes tirzepatide (Mounjaro) as this is a separate option used later on. People often refer to term glucagon like peptide -1 a (GLP-1) agonists when referring to tirzepatide rather than their full description 'glucagon like peptide -1 agonists/glucose dependent polypeptide (GLP-1/GIP) agonists. Please clarify.	Thank you for your comment. We have added in the term 'GLP-1 receptor agonist or tirzepatide' to make it clearer where tirzepatide is included with GLP-1 receptor agonists in recommendations and where it is not throughout the guideline and visual summary.
NHS West Yorkshire ICB	Visual summary	002		Column 2 (Obesity -Green box) 'Consider adding a GLP-1 receptor agonist if not already taking one and initial therapy started 3 months ago or more' The earlier use of glucagon like peptide -1 agonists (GLP-1 agonists) for glycaemic lowering is based on cost effectiveness using generic liraglutide,	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is

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				therefore add 'use drug with lowest acquisition cost' or state 'liraglutide' if this is the intention.	equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS West Yorkshire ICB	Visual summary	002		Column 1 (no relevant co-morbidities box) – Why are glucagon like peptide -1 agonists and glucose dependent polypeptide agonists (incretin therapies) no longer an option for people with poor glycaemic control, who are overweight (not obese) and where insulin therapy would have significant occupational implications? Has occupational hazards been considered?	Thank you for your comment and for raising this important point. GLP-1 receptor agonists and tirzepatide are not available for people with no relevant comorbidities as while there was evidence that indicated potential benefits in providing cardiovascular protection and reducing HbA1c and weight, the treatment was not cost effective and when weighing up the benefits and the risks of treatment and taking into account the cost and resource impact to the NHS it was agreed to not recommend this drug for people with no relevant comorbidities. This is not a change in previous guidance as GLP-1 receptor agonists and tirzepatide were not recommended for this group in the previous NICE guideline (as

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					we have a separate section for people living with obesity). DPP-4 inhibitors are recommended as further treatment if individual glycaemic targets are not met. Therefore, this is an option for people in this treatment group. Occupational hazards have been considered by the committee while making recommendations and these are reinforced by the shared decision making guideline which is referred to throughout. .
NHS West Yorkshire ICB	Visual summary	002		Column 2 (Obesity)- there is no mention of adjusting BMI for ethnicity, which could lead certain groups missing out on glucagon like peptide -1 agonists and glucose dependent polypeptide agonists (incretin therapies).	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about BMI, users should refer to the main guideline document. . . The guideline now includes a cross-reference to a definition of obesity in NICE's guideline on overweight and obesity management.
NHS West Yorkshire ICB	Visual summary	002		Column 3 (Chronic Kidney Disease) – 'eGFR above 30ml/min/1.73m ² - offer metformin'. We are concerned that people may overlook that a dose reduction is needed if eGFR< 45ml/min/1.73m ² . Please make this clearer by adding 'reduce dose if eGFR< 45ml/min/1.73m ² '	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. This information has not been included as prescribers are expected to understand the BNF and product characteristics for the medicines that they are prescribing, which state about the particulars of the medicines they are using.
NHS West Yorkshire ICB	Visual summary	002		Column 3 (chronic kidney disease) After dapagliflozin or empagliflozin add 'use drug with lowest acquisition cost' and the reason why it	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to

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				names these 2 drugs, when drug class mentioned elsewhere.	recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS West Yorkshire ICB	Visual summary	002		Column 3 (chronic kidney disease) – why are glucagon like peptide -1 agonists (semaglutide) not included as an option to reduce kidney outcomes and cardiovascular disease? Were the results of the FLOW study not taken into account?	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor

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					agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
NHS West Yorkshire ICB	Visual summary	002		Column 4 (early onset diabetes). We are concerned that there is no reference to the diabetes remission programmes in this group, before starting drug therapy, if within 6 years of diagnosis. Please add this.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
NHS West Yorkshire ICB	Visual summary	002		Column 4 (early onset diabetes). We are concerned about the use of metformin and sodium- glucose transport (SGLT2) inhibitor drugs first line. There is no clear indication on the algorithm that these choices have been chosen based on the assumption that this cohort more likely to be living with overweight/obesity. There are risks that sodium- glucose transport (SGLT2) inhibitor drugs could be initiated in a young person with normal weight who may have type 1 diabetes or Latent Autoimmune Diabetes in Adults, resulting in diabetic ketoacidosis. We suggest you add a	Thank you for your comment. Diagnosis of type 2 diabetes is not part of this review. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. In addition to the increased likelihood of living with obesity, people with early-onset type 2 diabetes are more likely to develop worse outcomes long term if not treated early and therefore treatment should be escalated for this population.

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				comment around checking diagnosis before following this treatment arm.	
NHS West Yorkshire ICB	Visual summary	002		Column 4 (early onset diabetes) – please define what age is considered 'early onset' Needs clarification.	Thank you for your comment. The definition of early onset as before age 40 has been added to the visual summary.
NHS West Yorkshire ICB	Visual summary	002		Column 4 (early onset diabetes) 'consider adding GLP-1 receptor agonist'- the aim of starting this group early is to reduce cardiovascular risk, therefore shouldn't it state 'use glucagon like peptide -1 agonists/ glucose dependent polypeptide agonists with proven cardiovascular benefit'	Thank you for your comment. This has been changed to 'GLP-1 receptor agonist or tirzepatide' to make it clear that this includes tirzepatide. However, to note, we have received insufficient evidence to confirm that tirzepatide has cardiovascular and renal protection effects and so cannot say that tirzepatide is effective in providing cardiovascular risk reduction.
NHS West Yorkshire ICB	Visual summary	002		Column 4 (early onset diabetes) 'consider adding GLP-1 receptor agonist'- does it need to be clearer that treatment doesn't include tirzepatide therapy, as people often use the term interchangeably for glucagon like peptide -1 agonists and combined glucagon like peptide -1 agonists/ glucose dependent polypeptide agonist therapy.	Thank you for your comment. This has been changed to 'GLP-1 receptor agonist or tirzepatide' to make it clear that this includes tirzepatide.
NHS West Yorkshire ICB	Visual summary	002		Column 5: heart failure, further treatment needed to reach weight management in preserved ejection fraction – add reason for subcutaneous semaglutide being named glucagon like peptide -1 agonist of choice i.e. the evidence based..	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information please refer to the "People with heart failure" section of the guideline.

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NHS West Yorkshire ICB	Visual summary	002		Column 5: heart failure. Why are Dipeptidyl peptidase 4 (DPP-4) inhibitors not an option where further treatment is needed to reach glycaemic target? Although they don't provide significant reductions in glucose, they are available generically at low cost, and aren't associated with hypoglycaemia (which is a risk in people with heart failure)	Thank you for your comment. Following on from the initial treatment, subcutaneous semaglutide is to be considered if glycaemic targets are not met for this population. Therefore if a person is taking a GLP-1 receptor agonist, they should not receive DPP-4 inhibitors as there is no clinical added benefit in combining the two drug classes.
NHS West Yorkshire ICB	Visual summary	002		Column 6: Atherosclerotic cardiovascular disease. Starting with triple therapy, including a subcutaneous injection will be a challenge in practice, and will need supporting information for patients for them to understand the benefits and for clinicians to confidently start treatment with 3 sequential .	Thank you for your comment. We appreciate this feedback. NICE is considering developing a clinician discussion aid to help support implementation of this.
NHS West Yorkshire ICB	Visual summary	002		Column 6: Atherosclerotic cardiovascular disease. Patients will already be prescribed multiple cardiovascular secondary prevention medication. We have concerns about patient acceptability of starting 3 sequential agents, further adding to medication burden/polypharmacy. Some resources to support people living with diabetes would be helpful.	Thank you for your comment. We appreciate this feedback. We agree that there is value in a patient decision aid in this area. NICE is considering developing a clinician discussion aid to help support implementation of this
NHS West Yorkshire ICB	Visual summary	002		Column 6: Atherosclerotic cardiovascular disease- Why is DDP4-inhibitors not an option where further treatment is needed to reach glycaemic target? Although they don't provide significant reductions in glucose, they are available generically at low cost,	Thank you for your comment. Initial treatment includes subcutaneous semaglutide because it showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes and atherosclerotic cardiovascular disease.

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				and aren't associated with hypoglycaemia (which is a risk in people with atherosclerotic cardiovascular disease)	If a person is taking a GLP-1 receptor agonist, they should not receive DPP-4 inhibitors as there is no clinical benefit in combining these drug classes as discussed in the relevant rationale and impact section. Therefore sulfonylureas, pioglitazone or an insulin-based treatment are recommended if further treatment is needed to reach a person's glycaemic target
NHS West Yorkshire ICB	Visual summary	002		Column 6: Atherosclerotic cardiovascular disease. Should glucagon like peptide -1 agonists and glucose dependent polypeptide agonists (incretin therapies) be used in people with ASCVD and normal weight? This needs to be clarified in the algorithm as people are used to using this group in people with type 2 who are overweight/obese.	Thank you for your comment. The BNF states the side effects of decreased appetite and decreased weight for semaglutide. Therefore, these side effects should be taken into consideration when assessing a person's requirements and decided if it is an appropriate medicine or not (for example a person living with underweight). The committee have made a recommendation in the "Reviewing other medicines" section to recommend stopping GLP-1 receptor agonists or tirzepatide if the person taking it becomes underweight (BMI under 18.5 kg/m ²).
NHS West Yorkshire ICB	Visual summary	002		Drug groups are referred to throughout, but where names are mentioned within a class, the reason for this should be made clear, e.g. dapagliflozin and empagliflozin in kidney disease (due to licenced indications), subcutaneous semaglutide (evidence base) – a key with abbreviations could be added at the bottom.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about by specific drugs are recommended, please refer to the relevant rationale and impact sections of the guideline.

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NHS West Yorkshire ICB	Visual summary	002		There is no mention of using the 'drug with lowest acquisition cost' when generic versions are available for some drugs e.g. sitagliptin, dapagliflozin, liraglutide, biosimilar insulin. No reference is made to this throughout the visual summaries and is only referred to in the guidance document when referring to Dipeptidyl peptidase 4 (DPP-4) inhibitors drugs.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS West Yorkshire ICB	Visual summary	002		Drug groups are generally referred to as at class level for sodium- glucose transport (SGLT2) inhibitor drugs, however there are differences within this class in terms of evidence on cardio-renal benefits. One of the justifications for using these earlier in the guidance it to prevent development of	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is

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				cardiovascular or renal disease later, therefore, to avoid having to switch drugs within a class, we suggest adding 'use drug with lowest acquisition cost with proven cardiovascular and renal benefits' after all sodium- glucose transport " (SGLT2) inhibitor drugs in the algorithm, and guideline document.	equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS West Yorkshire ICB	Visual summary	002		There is no information on when to stop or de-escalate therapy if people achieve their individualised HbA1c targets. We realise that this may be out with the scope of the guidance, but we are asked about often, especially regarding glucagon like peptide -1 agonists and glucose dependent polypeptide agonists (incretin therapies) drugs.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information please refer to the "Reviewing other medicines" section of the guideline. In the committee's experience, when some people have their medications stopped after they reach their glycaemic targets, it can lead to their HbA1c levels rising again. The recommendation for stopping GLP-1 receptor agonist or tirzepatide has been updated with reference to individualised

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					glycaemic control. The committee did not make specific glycaemic control targets as they can be arbitrary. SGLT-2 inhibitors are a good treatment option for most people and provide cardiorenal protection that cannot be measured by tests. Therefore, the committee agreed that these should be continued even if they do not help the person reach their glycaemic and weight targets.
NHS West Yorkshire ICB	Visual summary	002		The second page is impossible to see properly on a standard laptop or desktop screen, needs reformatting. Suggest reformatting and may need to go across 2 pages.	Thank you for your comment. We accept that there is a large amount of information for one page. We will be conducting an accessibility check for the visual summary however we believe that splitting the second page across 2 pages may cause more problems than the current layout.
NHS West Yorkshire ICB	Visual summary	002		General practitioners (GPs) have fed back that they have concerns about the ability to implement dual or triple therapy in primary care. This hasn't been widely uptake since the last guideline update, mainly due to difficulties persuading people to take metformin (ONE) medication, never mind two. We think the guidance needs to consider the challenges to address that.	Thank you for your comment. The aim is to work with people to decide if medication is the right option for them, rather than to persuade them to take medicine. If they decide medicine is not what they want after having all of the information and making an informed decision, then that is ok as per NICE's guidance on shared decision making which can provide support in this situation. Information in the guidance can provide support about information that can be used to inform people about reasons why to consider the medicines. Additionally NICE is considering developing a clinical discussion aid to accompany the guideline to help with this.
NHS West Yorkshire ICB	Visual summary	002		We are concerned about the time taken to initiate dual or triple therapy in all newly diagnosed patients. It takes time to outline the risks/benefits,	Thank you for your comment. NICE is considering developing a clinician discussion aid to accompany the guideline to help with this.

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				side effects and sick day rules. In atherosclerotic cardiovascular disease (ASCVD) there will be 3 therapies to initiate, one which is injectable and this takes time and resources. Some patient resources outlining the benefits, to support initiation of 2 or 3 therapies early on it their diagnoses, would be helpful	
NHS West Yorkshire ICB	Visual summary	002		Column 1 (no relevant co-morbidities box). We are concerned about the affordability of starting metformin and sodium- glucose transport (SGLT2) inhibitor drugs together as initial therapy in people without other co-morbidities which will benefit from SGLT2- inhibitors, especially given the lack of evidence base and potential for wasted medicines if not tolerated or not taken.	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease.
NHS West Yorkshire ICB	Visual summary	002		Column 1 (no relevant co-morbidities box). We think it will be challenging for primary care to start dual therapy with metformin and sodium- glucose transport (SGLT2) inhibitor drugs due to the time convincing people of the benefits of dual therapy ,especially when they have no existing co-morbidities. Some patient resources to support this would be helpful.	Thank you for your comment. NICE is considering developing a clinician discussion aid to accompany the guideline to help with this.
NHS West Yorkshire ICB	Visual summary	002		We have concerns that if side effects occur when starting dual treatment with metformin and sodium-glucose transport (SGLT2) inhibitor drugs, people may stop both therapies, not knowing which drug	Thank you for your comment. The visual summary now states to start medicines sequentially and not simultaneously and to confirm tolerability before moving on to the next step

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				caused the symptoms. This may lead to a lack of patient confidence in re-trialling these medicines.	
NHS West Yorkshire ICB	Visual summary	002		There is no reference about avoiding sodium-glucose transport (SGLT2) inhibitor drugs, in people with a high HbA1c level, due to the risk of diabetic ketoacidosis (DKA). We suggest some guidance about when this is not an appropriate first line treatment.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. The committee acknowledged that while a high baseline HbA1c can be a concern for starting an SGLT-2 inhibitor, it was not an absolute contraindication, and each case should be considered on a case-by-case basis. They outlined that it was more important to take into account other modifiable risk factors than providing a specific HbA1c threshold at which SGLT-2 inhibitors should be avoided. They ultimately agreed that the concern in this scenario is more about managing the causes of the adverse events, such as dehydration and volume depletion, that can increase the risk of events such as diabetic ketoacidosis; the recommendation on preventing DKA when taking SGLT-2 inhibitors has been updated to reflect this. Unfortunately, due to space constraints, it is not possible to add this information to the visual summary, but it is the expectation that prescribers would refer to the guideline document in these situations.
NHS West Yorkshire ICB	Visual summary	002		Has there been consideration to using modified release metformin first line due to reduced incidences of gastrointestinal adverse effects? i.e looking at cost effectiveness of standard v's modified release and incidence of gastro-intestinal side effects.	Thank you for your comment. The guideline has been amended following consultation and modified-release metformin is now recommended as first-line treatment as long as people do not have difficulty in swallowing modified-release metformin. This has also been amended in the visual summary.

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NHS West Yorkshire ICB	Visual summary	002		We like that the algorithm is taking a multimorbid approach and is less linear and restrictive than previous guidelines. It is well laid out and allows a more individualised approach to patient care, enabling better management of cardio-renal-metabolic disease and reducing risk. We like that it will extend access to sodium- glucose transport (SGLT2) inhibitor drugs for all people with type 2 diabetes and increase access to glucagon like peptide -1 agonists and glucose dependent polypeptide agonists (incretin therapies) for people with high risk co-morbidities and early- onset diabetes, therefore addressing lifetime risk.	Thank you for your comment
NHS West Yorkshire ICB	Visual summary	002		We recognise the benefits of sodium- glucose transport (SGLT2) inhibitor drugs and glucagon like peptide -1 agonists and glucose dependent polypeptide agonists (incretin therapies) in reducing cardiovascular risk. However, we are concerned about the significant cost implications to the National Health Service (NHS). Dapagliflozin is now available generically, which will reduce the costs of sodium- glucose transport (SGLT2) inhibitor drugs, however the increased use of incretin therapies throughout, will pose a huge financial challenge for integrated care boards. Given there is no set HbA1c or weight targets, to continue therapy. This could lead to less follow up and monitoring and the potential for NHS prescribed supplies to be diverted	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. This will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease.

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				to 'private' weight loss markets for personal financial gain.	
NHS West Yorkshire ICB	Visual summary	002		Column 5: heart failure - further treatment needed to reach weight management in preserved ejection fraction box. We suggest that you make it more prominent that it's for preserved ejection fraction only by labelling the arrow and/or bolding the text	Thank you for your comment. The visual summary has been updated with your suggestion.
NHS West Yorkshire ICB	Guideline	014	020	When referring to drug groups, the wording 'using the most cost effective choice' should be added to encourage the use of cheaper generic choices within drug groups.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given

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					the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
NHS West Yorkshire ICB	Guideline	019	009	Subcutaneous semaglutide for people with atherosclerotic cardiovascular disease. The committee recommended semaglutide, based on cost effective evidence and best clinical results, which were precise. As a result, the committee agreed on semaglutide rather than other glucagon like peptide -1 agonists. However, there is good evidence for using other glucagon like peptide -1 agonists in cardiovascular disease (LEADER, SURPASS CVD and REWIND trials) and some alternative therapy should be listed, in case semaglutide isn't tolerated.	Thank you for your comment. Of the trials you mention, only the data from REWIND was included in the analysis for people with atherosclerotic cardiovascular disease. The data from LEADER was included in the analysis for people with higher risk of CVD and people with heart failure, and not enough evidence was received for the SURPASS-CVD trial to assess cardiovascular and renal benefits for tirzepatide in people with atherosclerotic cardiovascular disease. Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide for people with atherosclerotic cardiovascular disease at this time.
NHS West Yorkshire ICB	Guideline	022	005	Offer basal insulin as the initial therapy. We are concerned that there is no mention of using biosimilars or most cost-effective choices for any of the insulin recommendations in the guideline.	Thank you for your comment. The guideline includes a recommendation that the basal insulin type (including biosimilars) with the lowest acquisition cost should be chosen where multiple types and regimens of basal insulin meet the person's needs.
NHS West Yorkshire ICB	Guideline	023	011-014	In the guideline it states to start the sodium-glucose transport (SGLT2) inhibitor drugs, as soon as tolerability with metformin is confirmed. This is	Thank you for your comment. We have added wording to the visual summary to clarify that drugs are to be initiated sequentially.

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				not represented in the visual summary, with no mention in the visual summary about confirming tolerability with metformin before starting SGLT2 inhibitor. Wording in the visual summary needs amending to reflect this.	
NHS West Yorkshire ICB	Guideline	023	015-016	'if using a GLP-1 receptor agonist, start this as soon as the SGLT-2 inhibitor tolerability is confirmed' this is not represented in the visual summary, with no mention in the visual summary about confirming tolerability. Wording in the visual summary needs amending to reflect this.	Thank you for your comment. We have added wording to the visual summary to clarify that drugs are to be initiated sequentially.
NHS West Yorkshire ICB	Guideline	025	014-015	Stop glucagon like peptide -1 agonists if: they do not help the person reach their glycaemic or weight targets', and the person does not have atherosclerotic cardiovascular disease. It's unclear what the weight or HbA1c target is, it would be helpful to quantify this set minimum expected. If not, may only achieve minimal weight loss or HbA1c reduction, which is not cost effective.	Thank you for your comment. Wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes.
North West London ICS	Guideline	018	014	Only dapagliflozin and empagliflozin is licensed for HF so if they are named specifically for T2DM + CKD because they are licensed, why not for this cohort i.e.T2DM and HF?	Thank you for your comment. The current UK marketing authorisations for SGLT-2 inhibitors are for the treatment of adults with type 2 diabetes mellitus (T2DM). Heart failure is not a separately licensed indication in section 4.1 of the SmPC. However, section 5.1 of the SmPC includes data on heart failure outcomes, reflecting the regulatory assessment that

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					these results are consistent with, and supportive of, the overall benefit–risk profile of SGLT2 inhibitors in T2DM. Therefore, it is appropriate to consider the benefits on heart failure outcomes within the scope of the approved indication when evaluating SGLT2. Given this, the committee agreed that a class based recommendation was appropriate in this circumstance.
North West London ICS	Guideline	020	005	The draft guideline recommend semaglutide for people with CVD (page 19 line 9), and considering the recommendation to add a GLP1 to the early onset cohort is based on CVD risk reduction, why is the choice of GLP1 left open? The draft guideline state semaglutide is the only GLP1 that is cost-effective for atherosclerotic CVD, I don't understand why it is not recommended by name for the early onset cohort.	Thank you for your comment. For those people with atherosclerotic cardiovascular disease and type 2 diabetes, of the GLP-1 receptor agonists and tirzepatide only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits. However, as noted in the committee discussion and rationale, of the GLP-1 agonists, only triple therapy with metformin, an SGLT-2 inhibitor and liraglutide reported an ICER approaching £20,000 per QALY gained for people with early-onset type 2 diabetes. Therefore, the committee made a class-level recommendation in this population. We did not find any specific evidence for adults 18 to 25 years that met our review protocol. The committee identified this as a gap in the evidence and therefore made a research recommendation around treatments for people with early-onset type 2 diabetes.
North West London ICS	Guideline	020	015	Why no recommendation for a GLP1 as initial medication? I note the committee says there is no specific evidence for people with obesity hence recommending the same medicines as for people with no specific comorbidities. This cohort will also	Thank you for your comment. The committee recommended initial treatment with an SGLT-2 inhibitor in addition to metformin because of the cardiovascular and renal protective benefits of SGLT-2 inhibitors. The committee discussion highlights the committee's experience that it is possible for

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				be at high risk of CVD so appears inconsistent with the recommendations for early onset diabetes. Clinical practice has a significant focus on obesity in T2DM and reducing weight can lead to remission. The apparent lack of evidence is contradictory to clinical practice.	people to have marked improvements in weight with an SGLT-2 inhibitor and metformin. Therefore, GLP-1 receptor agonists or tirzepatide should only be added at least 3 months after initial treatment with metformin and an SGLT2 inhibitor, which is covered in recommendations on treatment options if further medicines are needed. If the person's glycaemic targets have not been met, then there is a consider recommendation around using triple therapy with a GLP-1 receptor agonist or tirzepatide. If the person's weight targets have not been met, then this is outside the scope of this guideline, and users should refer to NICE's guideline on Overweight and obesity management [NG246] .
North West London ICS	Guideline	029	012	The committee states: "Evidence showed that no GLP-1 receptor agonist reached the cost-effectiveness threshold in the base-case analysis for people living with obesity. However, the committee considered sensitivity analyses where the price for liraglutide reduced further following the expiration of the medicine's patent in November 2024. It became cost-effective when the price reduced by 35%. Given this, they agreed that there was potential for GLP-1 receptor agonists to be cost effective under specific circumstances." The draft guideline does not recommend a specific GLP1 even though according to your own evidence liraglutide is the only one that is cost-effective. Why is that and should liraglutide be specified?	Thank you for your comment. The committee agreed that no GLP-1 receptor agonist should be specified. While this section stated that liraglutide was cost-effective in one sensitivity analysis, the committee have recommended that any GLP-1 receptor agonist or tirzepatide can be considered for people in this population given that all available GLP-1 receptor agonists showed glycaemic benefits and some cardiovascular benefits. The most clinically effective was subcutaneous semaglutide which was slightly over the threshold for cost-effectiveness. On the other hand, liraglutide was cost effective but was less clinically effective. Other GLP-1 receptor agonists and formulations of GLP-1 receptor agonists (such as oral semaglutide) were not cost effective and were comparatively less clinically effective. Tirzepatide was shown to be cost effective in the technology appraisal for people with type 2 diabetes but did not have evidence for cardiovascular and

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					renal benefits, which GLP-1 receptor agonists did have. This produced uncertainty in the evidence. Given this, they made a weaker consider recommendation in this case.
Northern Lincolnshire and Goole NHS Trust	Guideline	004	005	Excellent holistic statement	Thank you for your comment.
Northern Lincolnshire and Goole NHS Trust	Guideline	009	023	Very helpful	Thank you for your comment.
Northern Lincolnshire and Goole NHS Trust	Guideline	012	021	isCGM is now a redundant phrase. All APP based CGM is real time(rtCGM). Some readers need scanning and so isCGM but the default is real time and we would not ever 'offer' isCGM.	Thank you for your comment. This section is out of scope for the guideline update.
Northern Lincolnshire and Goole NHS Trust	Guideline	014	010	All guidance on CGM is from 2022 if not earlier. Commissioners need to be considering where CGM could facilitate more effective patient management and medicine optimisation by allowing remote review of CGM data.	Thank you for your comment. This section is out of scope for the guideline update.
Northern Lincolnshire and Goole NHS Trust	Guideline	017	010	This is excellent	Thank you for your comment.
Northern Lincolnshire	Guideline	018	001	Visual flow chart describes this as 'No relevant comorbidities' which I think is better and 'no	Thank you for your comment and this useful feedback. This has been changed to match the term used in the visual summary.

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and Goole NHS Trust				significant' may well become 'significant' over time if not appropriately managed.	
Northern Lincolnshire and Goole NHS Trust	Guideline	018	011	The flow chart talks about injectable Semaglutide in HF but what about Tirzepatide with evidence from the Summit trial in HFpEF. Likewise Rybelsus with the SOUL Trial.	Thank you for your comment and providing information about these interesting trials. The Summit trial was for people with heart failure with preserved ejection fraction and obesity but not necessarily type 2 diabetes. The SOUL trial was released after the final literature search for the guideline development period and so was not identified. Thank you for providing this study, we have added it during the consultation period, the findings of which support the current conclusions
Northern Lincolnshire and Goole NHS Trust	Guideline	019	002	That about Dulaglutide (REWIND Study) or Tirzepatide, SURPASS & SURPASS CVOT, latter with its non-inferior data when compared to Dulaglutide.	Thank you for your comment. Of the trials you mention, only the data from REWIND was included in the analysis for people with atherosclerotic cardiovascular disease. SURPASS was included in the analysis for people with higher risk of CVD and not enough data was received from the SURPASS-CVOT trial to assess cardiovascular and renal protection. Therefore of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes.
Northern Lincolnshire and Goole NHS Trust	Guideline	020	011	Could it include potential for switching between GLP1 based therapy if HbA1c target not achieved. The previous hierarchy of GLP1 efficacy was helpful.	Thank you for your comment. The committee made recommendations at the class level for the population of people with early onset type 2 diabetes due to the uncertainty around estimates of differences in effectiveness between individual GLP-1 receptor agonists. There are recommendations for people with early onset type 2 diabetes who require further medicines to reach their glycaemic targets,

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					which recommend adding a sulfonylurea or pioglitazone or an insulin-based treatment. NICE guideline recommendations are for individual health and social care professionals, who should use them together with their own judgement and discussion with people using services. Therefore, healthcare professionals should use their own judgement where the recommendations do not meet the specific needs of service users.
Northern Lincolnshire and Goole NHS Trust	Guideline	021	010	Why no mention of Canagliflozin (CREDENCE) trial, which possibly has the strongest evidence among SGLT2i for reno-protection. Why no mention of GLP1 based therapies with all currently used GLP1's have clinical trial data on renal protection and use down to eGFR of 15 ml/min/1.73 Also FLOW Trial (Semaglutide injectable)	Thank you for your comment. The CREDENCE and FLOW trials were included in this review. The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m². While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The differences from the KDIGO 2024 guideline are likely as health economics is not considered alongside the clinical evidence when making recommendations. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach

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					glycaemic targets (as per guidance about choosing which comorbidity to manage).
Northern Lincolnshire and Goole NHS Trust	Guideline	027	002	As previously – why no mention of Tirzepatide (SUMMIT) and SURPASS CVOT?	Thank you for your comment. The SUMMIT trial includes people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update. As for the SURPASS-CVOT, while we have seen these findings, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review. Therefore, not enough evidence was received for the trial to assess cardiovascular and renal benefits for tirzepatide in people with atherosclerotic cardiovascular disease
Northern Lincolnshire and Goole NHS Trust	Guideline	028	013	Discuss potential trail of alternative GLP1 based therapy if personalised glycaemic target not attained.	Thank you for your comment. It has been recommended that an addition of a sulfonylurea, pioglitazone or an insulin-based treatment be added if the person's individualised glycaemic target is not attained following the commencement of a GLP-1 receptor agonist. There is an absence of evidence for people with early-onset type 2 diabetes, and therefore a research recommendation has been made to understand more about clinical effectiveness of GLP-1 receptor agonists in this population.
Northern Lincolnshire and Goole NHS Trust	Guideline	038	026	Should we not be discussing the role of Fenofibrate in advance retinopathy base on ACCORD EYE and FIELD Studies. At R2 and R3 retinopathy patients would generally be very keen to try any available	Thank you for your comment. Fenofibrate was out of scope for this guideline update. Guidance on fenofibrate can be found in NICE's guideline on diabetic retinopathy .

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				option to prevent or delay further deterioration to their eyesight / retinopathy status.	
Novo Nordisk	General			Thank you for this opportunity to comment. Novo Nordisk welcomes the ambition of the updated draft guideline to recognise the need to further address and prevent the complications of type 2 diabetes, including cardiovascular disease and chronic kidney disease. It is very positive to see that the proposed guideline offers a more personalised and holistic approach to care, and places emphasis on increasing access to innovative treatments that have a breadth of clinical evidence beyond glycaemic control and that demonstrate reductions in the complications of type 2 diabetes. We believe we have identified areas of uncertainty and some limitations in the economic analysis. However, it is important to emphasise that we firmly believe any subsequent updates to the economic analysis be pragmatic and expeditious to avoid further delays to this essential clinical guideline, which will already be issued substantially later than the original schedule.	Thank you for your comment. We have addressed your comments on the economic analysis in other sections of the document. We amended the application of the Bagust & Beale formula disutility when BMI was greater than 25kg/m2. This altered the ICERs in the analysis, however recommendations remained the same. During development, a new version of the model became available, requiring us to rerun the analyses. Although this caused an unavoidable delay, we considered it most important to use the updated model so that our recommendations were based on the most robust and reliable evidence. Within this context, we believe the economic analysis was both pragmatic and expeditious as a more robust analysis in the first instance generally requires less involvement during the consultation phase.
Novo Nordisk	Visual Summary			Please note there is a typo in the title 'no relevant comorbidities.	Thank you for your comment. This mistake has been amended, thank you for bringing it to our attention.

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Novo Nordisk	Health economic analysis	023-029	Tables 007 to 015	The analysis in people with chronic kidney disease (CKD) is based on limited data. Gaps in the NMA: The clinical review identified 27 studies in people with type 2 diabetes and CKD. However, the networks applied in the network meta-analysis (NMA) contain far fewer studies and reflect very few of the treatments. While a large-scale literature review was conducted, there are significant gaps in the NMA due to lack of available data: - HbA1c: 24 studies of 18 interventions (however, this network was not used in the modelling analysis, with HbA1c changes instead taken from the high risk of cardiovascular disease [CVD] network) - Weight: Six studies of six treatments - Cardiovascular mortality: Nine trials of eight treatments (treatment difference versus placebo not estimable for four interventions) - Hospitalisation for heart failure: Nine trials of nine treatments (treatment difference versus	Thank you for your comment. The committee made a deliberate, a priori decision to apply a set of hierarchical rules to determine which treatment effects should be included or excluded in the health economic model, and how these effects should be carried over across different populations. Transparent decision rules minimise bias and ensures consistency in the modelling process. You correctly note that the HbA1c evidence network based on trials in people with CKD was not used in the model, which instead borrowed from the high risk of CVD network. This was because the CKD trial estimates had wide 95% confidence intervals – more than twice the minimally important difference in either direction, making them too imprecise to use. The committee also considered the transferability of treatment effects between populations. Where an effect was reported in one population but not another, they deemed it appropriate to assume a similar effect rather than no effect. In people with CKD, treatment effects for subcutaneous semaglutide were sourced from the FLOW study, where available. The committee agreed that evidence of clinical effectiveness was present, but that it did not demonstrate cost-effectiveness and therefore could not be recommended.

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				placebo not estimable for two interventions) • Non-fatal stroke: Three trials of four interventions (treatment difference versus placebo not estimable for one intervention, and wide confidence intervals for two interventions) • Non-fatal MI: Three trials of four interventions • Kidney failure: Three trials of four interventions • CKD analysis with no evidence specific to that population: Across the analysis, far more hazard ratio inputs are taken from NMAs conducted in other populations or were assumed to be 1 due to lack of data. It is significant that the lowest hazard ratio for CKD is in the dapagliflozin arm, with this evidence not from the CKD network. It is also noteworthy that several interventions are included in the CKD analysis with no evidence specific to that population. Given the limited data for most interventions, priority should be given to those where a large,	

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				long-term trial has been conducted in the population with type 2 diabetes and CKD as in the case with for s.c semaglutide in the FLOW study.	
Novo Nordisk	Health economic analysis	023-029	Tables 007 to 015	In is unclear how heterogeneity between studies included in the chronic kidney disease (CKD) NMA has been controlled for. This contributes to Novo Nordisk's concerns about how treatments costs and benefits have been modelled for those with CKD. It is unclear how heterogeneity between studies in the CKD NMA has been addressed, despite notable differences in baseline characteristics (e.g., age, HbA1c, blood pressure, BMI, eGFR, complication history) and standard of care, including use of SGLT-2 inhibitors, GLP-1 receptor agonists, and other renal treatments. These variations can significantly influence outcomes and trial comparability. Additionally, follow-up durations vary widely—from 24 weeks to more than 3 years. This raises concerns regarding the validity of proportional hazards assumptions. Proper adjustment for these factors is essential to ensure reliable NMA results.	Thank you for your comment. Details regarding the NMA are reported in evidence review F5. Heterogeneity between studies is acknowledged and the certainty of results downgraded accordingly (appendix J). The certainty of the evidence was considered by the committee when interpreting clinical and economic results. No adjustment was made to the NMA estimates before inclusion in the economic model.

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				The values used in the CEA appear to have undergone very little adjustment, as shown in the table below. <table><tr><td></td><td>Canagliflozin</td><td></td></tr><tr><td></td><td>CREDENCE</td><td>Value used</td></tr><tr><td>CV mortality</td><td>0.78 (0.61 to 1.00)</td><td>0.7</td></tr><tr><td>Hospitalisation for heart failure</td><td>0.61 (0.47 to 0.80)</td><td>0.6</td></tr><tr><td>Stroke</td><td>N/A</td><td>N/A</td></tr><tr><td>Myocardial infarction</td><td>N/A</td><td>N/A</td></tr><tr><td>Kidney failure</td><td>0.68 (0.54 to 0.86)</td><td>0.6</td></tr></table>		Canagliflozin			CREDENCE	Value used	CV mortality	0.78 (0.61 to 1.00)	0.7	Hospitalisation for heart failure	0.61 (0.47 to 0.80)	0.6	Stroke	N/A	N/A	Myocardial infarction	N/A	N/A	Kidney failure	0.68 (0.54 to 0.86)	0.6	
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Novo Nordisk	Health economic analysis	023-029	Tables 007 to 015	Across the economic analysis, the NMA data is frequently applied in populations to which it may not be suited, particularly in the chronic kidney disease (CKD) sub-population The analysis applies the same NMA data in the CKD stage 1–3 and CKD stage 4 analysis. Efficacy of treatments may vary across these subgroups. The CPRD cohort is very different to those enrolled in the CKD trials. Of particular note is that the CPRD cohort is substantially older than the trial populations, with lower HbA1c and blood pressure. In the CKD 1 to 3 cohort, eGFR is much higher than the trial cohorts, while in the CKD 4 cohort it is much lower.	Thank you for your comment. The committee made a deliberate, a priori decision to apply a set of hierarchical rules to determine which treatment effects should be included or excluded in the health economic model, and how these effects should be carried over across different populations. Maintaining transparent decision rules helps minimise bias and ensures consistency in the modelling process. The committee also considered the transferability of treatment effects between populations. Where an effect was reported in one population but not another, they deemed it appropriate to assume a similar effect rather than no effect. NICE would also want to avoid recommending interventions where the benefits are highly uncertain while the costs are substantial.																					

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				<table><tr><td></td><td>CREDENCE</td><td>FLOW</td></tr><tr><td>Age (years)</td><td>63.0</td><td>66.6</td></tr><tr><td>Duration of diabetes (years)</td><td>15.8</td><td>17.4</td></tr><tr><td>HbA1c (%)</td><td>8.3</td><td>7.8</td></tr><tr><td>BMI (kg/m²)</td><td>31.3</td><td>32.0</td></tr><tr><td>SBP (mmHg)</td><td>140.0</td><td>138.6</td></tr><tr><td>eGFR (mL/min/1.73m²)</td><td>56.2</td><td>47.0</td></tr></table> Evidence is applied in the CKD analyses from other NMAs. For example, all HbA1c changes and the majority of weight changes are taken from the high risk of cardiovascular disease NMA. People with existing comorbidities are likely to be treated less aggressively, and therefore these changes from the high risk of cardiovascular disease population may not be seen in the CKD population. This approach is also applied for the hazard ratios used for hard endpoints. It is significant that the lowest hazard ratio for CKD is in the dapagliflozin arm, with this evidence not based on the CKD network. It is also noteworthy that several interventions are included in the CKD analysis with no evidence specific to that population. Therefore, it cannot be considered appropriate not to recommend GLP-1 receptor agonists for people with type 2 diabetes and CKD based on an economic analysis associated with significant uncertainty.		CREDENCE	FLOW	Age (years)	63.0	66.6	Duration of diabetes (years)	15.8	17.4	HbA1c (%)	8.3	7.8	BMI (kg/m ²)	31.3	32.0	SBP (mmHg)	140.0	138.6	eGFR (mL/min/1.73m ²)	56.2	47.0	
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Novo Nordisk	Visual Summary	002		Clarification of terms We recommend the visual summary is amended to include a definition for Early-onset diabetes.	Thank you for your comment. The definition of early onset (before age 40) has now been added to the visual summary.
Novo Nordisk	Guideline and visual summary	015	014	The draft guideline states: “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.” This recommendation is not evidence-based. Many people have more than one comorbidity and a person-centred approach considers a choice of treatment that will mitigate risk factors as much as possible. As it is written, and using the example given, a person living with atherosclerotic cardiovascular disease and obesity may ‘choose’ to prioritise their obesity, leaving them at unnecessary risk of further cardiovascular disease. We suggest this is re-worded to ‘if a person has more than one comorbidity (for example atherosclerotic cardiovascular disease and obesity), make a shared decision with them about which treatment approach would best mitigate their overall risks.’	Thank you for your comment and for your assessment of the clinical realities of type 2 diabetes. The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it was most important to make recommendation based on the evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. However, the committee agree with your assessment of multiple comorbidities. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including: 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to advise people to account for: a) medicines required for cardiovascular and renal protection, b) medicines that are contraindicated, c) medicines optimisation especially for people with frailty. Further information can be found in the committee discussion document.

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Novo Nordisk	Health economic analysis	016	Table 004	The current modelling approach for type 2 diabetes and chronic kidney disease (CKD) underestimates the cost-effectiveness of renally protective treatments like semaglutide by failing to capture their full cost and QALY benefits. Key concerns include: • Clinical benefits overlooked: Despite guideline recognition, the renal benefits of semaglutide may not be adequately reflected in the cost-effectiveness estimates. Especially considering strong cost-effectiveness of semaglutide in subpopulations such as atherosclerotic cardiovascular disease (ASCVD) and heart failure, which have similar baseline characteristics in the NG28 analysis. The draft guideline states that GLP-1 receptor agonists help to 'reduce weight and long-term cardiovascular, renal and glycaemic complications better than other medications' (Guideline, page 78, lines 14-16). • Oversimplified CKD categorisation: Collapsing Kidney Disease Improving Global Outcomes (KDIGO) stages into broad groups masks important differences in progression and treatment impact.	Thank you for your comment. We have responded to each point separately below. Clinical benefits overlooked: The renal benefits of subcutaneous semaglutide was captured in the model via risk of established kidney disease, with treatment effects taken from Perkovic 2024. This was applied to all sub-populations. No treatment effects for oral semaglutide were identified during the clinical review. Since oral and subcutaneous semaglutide were classified as separate interventions, the committee agreed that treatment effects should not be shared between them. Oversimplified CKD categorisation: When considering how to subgroup CKD, the committee took a pragmatic approach and gave primary importance to how people are managed across the different stages. In the absence of specific treatment-related differences between CKD 1, CKD2, CKD3a and CKD3b, the committee did not think there were sufficient differences between them to warrant individual analyses. Quality of life: The clinical evidence review did not look at treatment-related effects on presence of proteinuria, and this therefore was not modelled. Costs:

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				Consequently, the economic model does not capture meaningful differences in costs and outcomes for people with different CKD stages (Economic Report, page 8, lines 22-23). For example, there are substantial differences in people who are CKD Stage 3b and CKD Stage 1. However, the economic model assumes that including CKD stages 1–3 as a homogeneous group is adequate for capturing costs and benefits of slowing progression. In reality, transition risks and intervention effects are non-linear across KDIGO categories. • Quality of life: The NICE analysis applied a disutility for EKD of –0.164, taken from the Beaudet <i>et al.</i> review, with the value for haemodialysis originally taken from Wasserfallen <i>et al.</i> Notably, this review also reported a disutility of –0.048 for proteinuria, which would be expected much earlier in the CKD staging pathway than EKD. The study by Jesky <i>et al.</i> 2016 reported EQ-5D score by CKD stage from 745 participants in the UK, with stages 3a, 3b and 4 having a notable impact on quality of life (https://pubmed.ncbi.nlm.nih.gov/27832126/). The utilities sourced from Beaudet <i>et al.</i>	Similarly, since established kidney disease is the only model outcome related to CKD outputted by the UKPDS model, costs and outcomes were captured at this level. The committee agreed that the costs associated with treating EKD were the largest cost and its inclusion could be considered a reasonable approximation. Scope misalignment: Treatment-related acute kidney injury was one of four adverse events included in the modelling, alongside development of established kidney disease (EKD) and EKD-related mortality. Model limitations: The largest predictor of established kidney disease (EKD) using the UKPDS risk prediction is the presence of micro/macroalbuminuria versus no micro/macroalbuminuria (HR=3.95), followed by a history of amputation (HR= 3.03). We utilised the UKPDS time-path risk prediction equations to predict the occurrence of micro/macroalbuminuria, which itself is dependent on patient risk factors such as sex, ethnicity, age at diagnosis, smoking status, systolic blood pressure, HbA1c, BMI and high-density lipoprotein. We would therefore expect differences in the presence of risk factors between populations (including presence of albuminuria) to correlate to differences in outcomes. Equalities considerations: The committee focused its consideration of access-related inequalities on the uptake of SGLT-2 inhibitors, as these are

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				and described in Table 30 are not internally consistent. For example, ulcer has a greater impact on quality of life than EKD, MI and stroke. Additionally, the same disutility is applied in the year of the event and in subsequent years, which does not reflect that complications have a larger impact on quality of life in the year of the event. • Costs: Kent <i>et al.</i> 2015 reported that CKD stage 1–3b (predominantly 3b), 4, 5 not on dialysis and dialysis were associated with significant hospital costs, increasing as the severity of nephropathy increased (https://pubmed.ncbi.nlm.nih.gov/25924679/). Similarly, Pollock <i>et al.</i> 2022 reported costs by eGFR and urinary albumin creatinine ratio, with costs increasing as kidney function worsened (https://pubmed.ncbi.nlm.nih.gov/36325010/). • Scope misalignment: Renal events like acute kidney injury and progression through CKD stages are excluded, underestimating cost and HRQoL impacts. The economic analysis does not align with the final scope with respect to the modelling of renal events. The final scope states that renal	recommended as a first-line option for nearly all people with type 2 diabetes. Inequalities relating to GLP-1 agonists were not examined empirically, given the more restrictive recommendations but equality of access was considered by the committee when making recommendations. Differences between the living with obesity and CKD recommendations: Whilst the outcomes of the economic model were similar between the CKD population and the living with obesity populations there was significantly more evidence for the living with obesity population leading to narrower credible intervals and more certainty in the effect estimates. Given that no evidence was identified for some effect estimates, borrowed from other populations or had very wide credible intervals the committee considered both the outcomes from the economic model and the evidence from the clinical evidence review when making recommendations. This is detailed in the Committee Discussion document. NICE generally avoid recommending interventions with uncertain evidence when there would be a substantial resource impact.

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				outcomes such as acute kidney injury, persistent signs of worsening kidney disease, development of ESKD, and death from renal cause would be considered. However, only development of ESKD has been specifically captured in the economic analysis. ESKD is a rare microvascular event that does not capture the overall cost and HRQoL impact of CKD in patients with type 2 diabetes. For example, in the economic analysis in the CKD 1-3 population, across all treatments a maximum of 3.31% of patients incurred ESKD at 10 years, which demonstrates how minimal of an impact modelling only the rare event of ESKD has on the economic analysis. By focusing renal impairment on the risk of ESKD and no other important renal outcomes, we believe NICE have significantly underestimated the cost and HRQoL impact of CKD on patients with type 2 diabetes. • Model limitations: UKPDS-based modelling may not suit high-risk CKD populations, leading to uncertainty in results. The UKPDS Outcomes Model 2 appears to underpredict ESKD, especially in CKD stage 4, with lower rates than seen	

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				in trials like CREDENCE and FLOW. This may be due to low baseline albuminuria and differences in participant profiles, making the model less suitable for high-risk populations. Underestimating ESKD limits the ability to show treatment benefits, impacting cost-effectiveness estimates. • Equalities considerations: The equality issues associated with people with CKD should be considered in the NG28 decision making. As discussed in TA1075, CKD disproportionately affects people of Black, Asian, and minority ethnic groups and lower socioeconomic backgrounds. People from these backgrounds are more likely to have faster progression to kidney failure and die earlier. The lack of a GLP-1 receptor agonist recommendation in people with type 2 diabetes and CKD leaves this population at a significant disadvantage compared to non-CKD type 2 diabetes populations where GLP-1 receptor agonists are recommended. Therefore, it cannot be considered appropriate to have no recommendation for GLP-1 receptor agonists for people with type 2 diabetes and CKD based on an economic analysis associated	

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				with significant uncertainty, especially given that the Committee acknowledge that GLP-1 receptor agonist have significant cardiorenal benefits in those with type 2 diabetes. It is unclear why comparable clinical and economic evidence has led to different recommendations across the obesity and CKD populations.	
Novo Nordisk	Guideline and visual summary	019	004	Novo Nordisk welcomes the recommendation of offering subcutaneous semaglutide as part of initial triple therapy in people with type 2 diabetes and atherosclerotic cardiovascular disease (ASCVD). This recommendation reflects the breadth of evidence available highlighting the clinical benefits of semaglutide in this population. In addition to the strength of the clinical evidence, semaglutide is considered the most cost-effective GLP-1 receptor agonist by a large margin, making it a valuable option for optimising patient care. Recommending semaglutide early in the treatment pathway will improve patient outcomes and bring long-term value to the healthcare system. Semaglutide is unique as a GLP-1 receptor agonist therapy in that it has demonstrated the broadest range of benefits beyond glycaemic control and weight loss for people with type 2 diabetes and other cardiometabolic diseases in the class:	Thank you for your comment. We appreciate your feedback and support of the recommendations.

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				ASCVD specific benefits ➤ SUSTAIN 6¹: this trial demonstrated that, compared to placebo, s.c semaglutide reduces major adverse cardiovascular events (MACE) (comprising non-fatal myocardial infarction [MI], non-fatal stroke and cardiovascular death) by 26%, in individuals with type 2 diabetes and established cardiovascular disease. ➤ SOUL²: this trial demonstrated that, compared to placebo, oral semaglutide was associated with a significantly lower risk of MACE, with a hazard ratio of 0.86 (95% CI 0.77–0.96), corresponding to a relative risk reduction of 14% in adults with type 2 diabetes, and ASCVD or chronic kidney disease or both. Importantly in the SOUL trial, the cardiovascular benefits of semaglutide were consistent across the baseline BMI categories. The results suggested that neither the change in A1c nor the change in body weight during the trial appeared to have a major influence on the impact of semaglutide benefit seen in MACE.³ ➤ STRIDE⁴, which is the first and only functional outcome RCT for a GLP-1	

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				receptor agonist in people with type 2 diabetes and peripheral artery disease (PAD), demonstrated that semaglutide improved function, symptoms, and quality of life in this population. The benefits of semaglutide on functional capacity in people with PAD and type 2 diabetes are weakly correlated with weight loss (change in BMI) and independent of glycaemic improvement (change in HbA1c). The functional benefits in those with PAD demonstrated in STRIDE are not captured in the cost-effectiveness analysis. ➤ The SOUL² and STRIDE⁴ results described suggest semaglutide-induced physiological changes beyond the magnitude of body weight loss and HbA1c. In addition to improving glycaemic control in type 2 diabetes and contributing to weight reduction, semaglutide has been shown to exert beneficial effects on the cardiovascular system by decreasing blood pressure, reducing levels of blood lipids, attenuating the development of atherosclerotic plaques and reducing systemic inflammation.^{5,6,7} The full mechanism of cardiovascular protection with semaglutide has not yet been	

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				elucidated and so there may be additional factors at play. ➤ REACH⁸: this is the first real-world study to directly compare cardiovascular outcomes among semaglutide (n=29,168) and dulaglutide (n=29,168) users. Results showed that compared with dulaglutide, semaglutide offered a superior reduction in the risk of MACE (MI, stroke, and death) by 23% (hazard ratio of 0.77, CI 0.71-0.84). The REACH study also reported that semaglutide was also associated with a 25% reduction in the risk of 5-point MACE (MI, stroke, hospitalization for unstable angina or heart failure, and death) and a 26% reduction in the risk of death compared to dulaglutide. Renal benefits ➤ FLOW⁹, the only dedicated renal outcome trial for a GLP-1 receptor agonist, demonstrated a statistically significant and superior reduction of 24% in major kidney disease events in people with type 2 diabetes and chronic kidney disease when treated with s.c semaglutide 1.0 mg	

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				compared to placebo, and added to standards of care. Liver benefits ➤ There is a well-established bi-directional relationship between type 2 diabetes and MASLD (Metabolic Dysfunction-Associated Steatotic Liver Disease).¹⁰ ESSENCE, which is an ongoing trial, evaluated the efficacy and safety of semaglutide 2.4mg compared to placebo, in addition to standard of care, in people with MASH (Metabolic-dysfunction Associated Steatohepatitis), fibrosis stage 2-3. Results from Part 1 of this trial have demonstrated that semaglutide is the first GLP-1 receptor agonist to achieve histological improvement in liver fibrosis and MASH resolution in significantly more participants, compared to placebo, in a Phase 3 clinical trial.¹¹ ➤ In a post-hoc analysis of ESSENCE, the impact of baseline glycaemia on liver biomarkers and histology was assessed. Of the 800 participants, 190 had	

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				prediabetes (128 receiving semaglutide and 62 receiving placebo) whilst 478 had type 2 diabetes (316 received semaglutide vs 162 placebo). Across glycaemia groups, differences in responder proportions favoured semaglutide for the co-primary histological endpoints of improvement in liver fibrosis and MASH resolution.¹² Summary The recommendation to offer s.c semaglutide as part of a triple therapy alongside metformin and an SGLT-2 inhibitor earlier in the treatment of people with type 2 diabetes and ASCVD is supported by clear cost effectiveness and extensive clinical evidence highlighting the unique benefits of this GLP-1 receptor agonist in this population. Semaglutide has been shown to: ➤ Reduce the risk of major adverse cardiovascular events in people with type 2 diabetes and ASCVD. ➤ Reduce the risk of major kidney disease in patients with type 2 diabetes and chronic kidney disease.	

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				➤ Improve functional outcomes in patients with type 2 diabetes and peripheral artery disease. ➤ Provide significant and clinically meaningful reduction in HbA1c & weight. References 1. Marso S <i>et al.</i> N Engl J Med. 2016;375(19):1834-1844. 2. McGuire D <i>et al.</i> N Engl J Med. 2025. 3. Inzucchi S. Presentation, 85th Scientific Sessions of the American Diabetes Association; June 2025; USA. 4. Marc B <i>et al.</i> Lancet. 2025;405(10489):1580-1593. 5. Zhao X <i>et al.</i> Front Endocrinol ; 2021;12:721135. 6. Rakipovski G <i>et al.</i> JACC Basic Transl Sci. 2018;3(6):844-857. 7. Piccirillo F <i>et al.</i> Int J Mol Sci. 2023;24(12). 8. Xi Tan <i>et al.</i>, Presentation at the European Association for the Study of Diabetes (EASD) 61st Annual Meeting, September 2025, Austria. 9. Perkovic V <i>et al.</i> N Engl J Med. 2024. https://doi.org/10.1016/j.jacc.2024.08.004 10. Metabolic Dysfunction–Associated Steatotic Liver Disease (MASLD) in People With	

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				Diabetes: The Need for Screening and Early Intervention. A Consensus Report of the American Diabetes Association 11. Sanyal AJ et al. N Engl J Med 2025;392(21):2089–2099. Roden M et al. Presented at the European Association for the Study of Diabetes (EASD) September 2025, Austria.	
Novo Nordisk	Guideline and visual summary	020	002	Novo Nordisk welcomes the recommendation that GLP-1 receptor agonist therapy is considered in people with early onset type 2 diabetes. Early-onset type 2 diabetes, which develops during critical life stages, profoundly disrupts education, employment, reproductive health, and long-term wellbeing. Its aggressive course, characterized by rapid complication onset and shortened life expectancy, imposes a substantial clinical and economic burden on patients and healthcare systems.¹ While there was limited evidence identified for this population, early intervention with effective pharmacotherapy such as a GLP-1 receptor agonist has the potential to profoundly impact the long-term health trajectory of this population.² Reference	Thank you for your comment. We appreciate your feedback and support of the recommendations.

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				1. Lim L, <i>et al.</i>, Lancet 2025; 405: 2327–40 2. Misra S, <i>et al.</i>, Lancet 2025; 405: 2341–54	
Novo Nordisk	Guideline and visual summary	021	006	In the recommendations for people with chronic kidney disease (CKD), semaglutide should be included as a treatment option. The current draft recommendation is inconsistent with the clinical data for semaglutide in this population, and in the economic analysis the approach for the CKD subgroups has limitations and inconsistencies that means the cost effectiveness is likely to be underestimated. Given the significant emphasis placed on the importance of cardiorenal benefits of treatments within NG28, it is unclear why DPP-4 inhibitors were recommended instead of semaglutide for use in people with type 2 diabetes and CKD. In the Committee Discussion (pages 35-36), the Committee state that <i>'GLP-1 receptor agonists will provide additional cardiovascular and renal protection, and weight reducing benefits that are more useful than the benefits of the DPP-4 inhibitor for most people'</i>. However, the NG28 recommendations in the CKD population contradict	Thank you for your comment. The rationale for DPP-4 inhibitors can be read in the rationale and impact section. The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m². Major kidney disease events as reported on the FLOW trial was not a prespecified outcome in the protocol, but was considered qualitatively by the committee alongside the benefits that were prespecified in the guideline. While the FLOW trial showed clinically important benefits in renal and cardiovascular protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets

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				this statement and do not reflect the acknowledged renal protection of semaglutide. Detailed comments on the economic analysis and evidence synthesis are added in separate comment rows that tie back to the specific relevant sections of the NICE guideline supporting documentation. However, key issues with the economic analysis approach for the CKD subgroup include: - The inconsistent evidence base used to inform the cardiovascular treatment effects. For example, the hazard ratio (HR) for non-fatal stroke for s.c semaglutide is applied from the FLOW study which is highly uncertain and is inconsistent with the statistically significant stroke benefit applied for those with atherosclerotic cardiovascular disease (ASCVD) (Hazard Ratios of 1.22 versus 0.62, respectively). For other comparators, cardiovascular treatment effects have been transposed from non-CKD focussed studies. - The approach to modelling people living with type 2 diabetes and CKD does not fully capture all the cost and quality-adjusted life year (QALY) benefits of treatments that offer renal protection and delay the progression of CKD	(as per guidance about choosing which comorbidity to manage). Where other points have been made as specific comments, we have addressed these in the responses to those specific comments.

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				Novo Nordisk acknowledges that the FLOW study was considered as part of the evidence base, however we have provided additional clinical rationale and justification for why we believe that the exclusion of semaglutide from the CKD population should be reconsidered. The need to strengthen strategies for cardiorenal protection in people with type 2 diabetes & chronic kidney disease Diabetes is a major cause of End Stage Renal Disease (ESRD), with nearly one in three individuals requiring dialysis or a transplant, and one in five requiring kidney disease treatment in their lifetime. Moreover, CKD and cardiovascular disease often exacerbate each other, leading to a significantly increased risk of morbidity and mortality, especially in individuals with diabetes. ¹ CREDENCE², DAPA-CKD³, and EMPA-KIDNEY⁴ studies have shown that SGLT-2 inhibitors slow CKD progression and improve cardiovascular outcomes. However, despite the benefits of these medicines, significant residual risk remains, and many patients still experience kidney function decline or mortality during treatment. ^{2,3,4} This highlights the need for the use of additional therapies like semaglutide to further reduce the	

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				residual risk of progression of CKD and cardiovascular risk in people with type 2 diabetes. Clinical evidence for s.c semaglutide in people with type 2 diabetes and CKD 1. Major kidney disease events outcomes The FLOW trial demonstrated a statistically significant reduction of 24% in the primary outcome (composite of kidney failure, $\geq 50\%$ reduction in eGFR, or death from kidney-related or cardiovascular causes) in people with type 2 diabetes and CKD when treated with OW s.c semaglutide 1.0 mg vs placebo added to standard of care.⁵ Kidney-specific outcomes were similarly reduced, with a slower decline in kidney function and a 40% reduction in the urine albumin-to-creatinine ratio (uACR). These results highlight the potential of semaglutide to slow the progression of kidney disease in this high-risk population.⁵ 2. Major cardiovascular outcomes & mortality In the FLOW trial, semaglutide reduced the incidence of major adverse cardiovascular events	

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				(MACE), a secondary outcome, by a significant 18% over a median follow-up of 3.4 years. Cardiovascular mortality and all-cause mortality were also significantly reduced by 29% and 20%, respectively in this trial.⁵ 3. Heart failure benefit in people with type 2 diabetes and CKD A prespecified analysis of FLOW trial evaluated the effects of semaglutide on heart failure outcomes in this high-risk population. This analysis demonstrated that semaglutide significantly decreased a composite outcome of time to first heart failure events or cardiovascular death by 27%, heart failure events alone by 27%, and cardiovascular death by 29% compared with placebo in participants with CKD and type 2 diabetes.⁶ 4. Cardiovascular and renal benefits of s.c semaglutide across CKD disease continuum: ➤ In the SUSTAIN-6 trial, semaglutide significantly lowered the risk of nephropathy progression to new or worsening nephropathy by a significant 36% (mainly	

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				driven by delaying progression of macroalbuminuria). This suggests a broad benefit for kidney health in people with type 2 diabetes at high cardiovascular risk.⁷ ➤ Post-hoc eGFR slope analyses of FLOW data suggests that semaglutide may delay the onset of kidney failure or the requirement for chronic kidney replacement therapy by up to 5 years compared to placebo, across eGFR subgroups (high (≥ 60 mL/min/1.73 m²) vs low (≤ 45 mL/min/1.73 m²)).⁸ ➤ Primary and secondary analysis from the FLOW trial demonstrated risk reductions in kidney and cardiovascular outcomes across varying severities of baseline CKD and cardiovascular disease. For example: • A consistent risk reduction was demonstrated by semaglutide in the composite kidney events, eGFR slope, MACE and all-cause mortality, irrespective of CKD severity defined by baseline eGFR, uACR, or Kidney	

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				Disease Improving Global Outcomes (KDIGO) risk category.⁹ Semaglutide reduces the risk of primary kidney outcomes or eGFR decline consistently, regardless of baseline cardiovascular status or total cardiovascular risk.¹⁰ 5. Glycaemic control Across all SUSTAIN¹¹ and FLOW⁵ trials, semaglutide showed consistent and significant reductions in HbA1c in all eGFR subgroups, demonstrating that it is an effective glucose-lowering agent in subjects with type 2 diabetes independently of baseline eGFR, including in those with CKD. The licence for semaglutide allows its use without dose adjustment for patients with mild, moderate or severe renal impairment to provide glycaemic control in people with type 2 diabetes.¹² Summary Type 2 diabetes, CKD, and cardiovascular disease are interconnected conditions that synergistically contribute to significantly poorer clinical outcomes and elevated mortality risk. Semaglutide has been shown to provide:	

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				• Proven renal protective effects across the continuum of renal disease • Reduction in major cardiovascular events including cardiovascular mortality • Improvement in heart failure outcomes • Reduced all-mortality • Clinically relevant and sustained improvements in glycaemic control and weight loss Novo Nordisk requests the Committee to consider reflecting the full breadth of evidence for semaglutide in this population with the following amendments to recommendations 1.8.24 & 1.8.26 (<i>proposed changes in italics</i>) and reflected in the visual summary: 1.8.24 For adults with type 2 diabetes and an estimated glomerular filtration rate (eGFR) above 30 ml/min/1.73 m²: ➤ Offer metformin and either dapagliflozin or empagliflozin. ➤ <i>Consider adding semaglutide.</i>	

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				➤ If metformin is contraindicated or not tolerated, offer either dapagliflozin or empagliflozin alone. ➤ <i>Consider adding semaglutide.</i> 1.8.26 For adults with type 2 diabetes and an eGFR of 20 ml/min/1.73 m² and up to 30 ml/min/1.73 m²: ➤ offer either dapagliflozin or empagliflozin alone. ➤ <i>Consider adding semaglutide.</i> References: 1. UKKA. Kidney Disease: A UK Public Health Emergency. 2023. 2. Perkovic V <i>et al.</i> N Engl J Med 2019;380:2295-306 3. Heerspink HJL <i>et al.</i> N Engl J Med 2020;383:1436-46 4. Herrington WG <i>et al.</i> N Engl J Med 2023;388:117-27 5. Perkovic V, <i>et al.</i> N Engl J Med. 2024; DOI: 10.1056/NEJMoa2403347 6. Pratley RE, <i>et al.</i> Journal of the American College of Cardiology 2024; https://doi.org/10.1016/j.jacc.2024.08.004	

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				7. Marso, S. P. <i>et al. N Engl J Med</i> 375, 1834-1844, 2016 8. Cherney D, <i>et al. Reduced kidney function decline with semaglutide across kidney risk categories: analyses from the FLOW trial; 62nd European Renal Association Congress; June 2025; Austria</i> 9. Mahaffey KW, <i>et al. European Heart Journal</i> 2024 10. Tuttle KR, AHA 2024, Oral presentation 11. Aroda VR, <i>et al. Diabetes Metab.</i> 2019;45:409–18 12. Novo Nordisk Ltd. Ozempic UK SmPC.	
Novo Nordisk	Guideline and visual summary	022	010	Proposed draft recommendations for use in frailty exclude any recommendation for a GLP-1 receptor agonist. GLP-1 receptor agonists are likely to be beneficial in frail older persons living with overweight or obesity due to their cardiorenal protective benefits beyond glycaemic control and weight loss^{1,2}. Frailty ranges from obesity to underweight, affecting body composition and insulin resistance (IR). Sinclair <i>et al.</i>,^{1,2} recently reviewed the characteristics and phenotype of frail older people with diabetes who should benefit from the use of SGLT-2 inhibitors or GLP-1RA. The anorexic	Thank you for your comment. The previous recommendations did not exclude any recommendation for GLP-1 receptor agonist, it just didn't have a recommendation explicitly for GLP-1 receptor agonists. The committee agree that their current stance is appropriate but have added a note in the rationale that there is no reason why someone, for whom GLP-1 receptor agonists are safe and there is a relevant indication, cannot take a GLP-1 receptor agonist. Therefore, people with frailty and living with obesity would be able to access a GLP-1 receptor agonist through the recommendation that specifies that people can choose to prioritise treatment for one comorbidity based on their treatment aims. While the STEP-HFpEF DM trial has been included, it was noted that the dose for weight management (2.4 mg weekly)

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				malnourished (AM) type involves weight loss, lower IR, and potential metabolic improvement, which can lead to better survival outcomes. In contrast, the sarcopenic obese (SO) type has high IR and worsened metabolic risks, accelerating diabetes and cardiovascular disease.^{1,2} Two studies have demonstrated the benefits of GLP-1 receptor agonist in people with frailty, beyond glycaemic control and weight loss: ➤ A retrospective analysis of 744,310 older patients ≥65 years of age with type 2 diabetes mellitus assessed cardiovascular effectiveness and safety of SGLT-2 inhibitors, GLP-1 receptor agonists and DPP-4 inhibitors across frailty levels. Over about 11 months, both SGLT-2 inhibitors and GLP-1 receptor agonists reduced cardiovascular event by 28% and 26%, respectively, compared with DPP-4 inhibitors. While relative risk reductions for the effectiveness outcomes remained stable across frailty strata, absolute reductions were larger in frailer patients at higher risk for these outcomes. Severe adverse events, seen more frequent in frailer patients, were not more common in	and in balancing the factors together, it was agreed that further evidence was required before using it for a specific recommendation for people with heart failure (and any other population) including evidence where the dose was the dose licensed for people with type 2 diabetes. Evidence from the STEP-HFpEF trial was considered during the update. However, evidence from STEP-HFpEF was not included as the population excluded people with diabetes. Kutz 2014 was also not eligible for inclusion as it was a cohort study, and only RCTs were eligible for inclusion according to the protocol. Sinclair 2025 and Sinclair 2025 were also not included as these were narrative reviews.

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				those using SGLT-2 inhibitors or GLP-1receptor agonists compared with DPP-4 inhibitors.³ ➤ Pandey <i>et al</i> analysed the effects of semaglutide in patients with obesity-related HFpEF, focusing on safety, efficacy and impact on frailty. Using data from the STEP-HFpEF and STEP-HFpEF DM trials^{4,5}, the authors created a frailty index and stratified 1,145 patients into three groups (non-frail, more-frail, and most frail). They found that semaglutide consistently reduced weight across all groups, but improvements in heart failure symptoms and physical function were greatest in the most-frail patients. Additionally, semaglutide (vs placebo) reduced the burden of frailty during follow-up with a greater increase in the proportion of non-frail participants and a concurrent decrease in the proportion of more frail and most frail participants at weeks 20 and 52. Semaglutide was also associated with fewer serious adverse events. These findings suggest that frail patients may	

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				benefit from semaglutide, supporting its use regardless of frailty status.⁶ Novo Nordisk recommends adding the following to 1.8.30 and the visual summary when Metformin is contraindicated or not tolerated, or if further treatment is needed to reach glycaemic targets: “Consider a GLP-1 receptor agonist in people with frailty if they are living with overweight or obesity” References 1. Sinclair A, <i>et al.</i>, The Use of SGLT-2 Inhibitors and GLP-1RA in Frail Older People with Diabetes: A Personalised Approach Is Required <i>Metabolites</i> 2025, 15, 49. 2. Sinclair A, <i>et al.</i>, The Effect of Frailty on Body Composition and Its Impact on the Use of SGLT-2 Inhibitors and GLP-1RA in Older Persons with Diabetes. <i>Metabolites</i> 2025, 15, 381 3. Kutz A, <i>et al.</i>, Diabetes. <i>Diabetes Care</i> 2023, 46, 2004–2014.	

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				4. Kosiborod, M. N. et al.. N. Engl. J. Med. 389, 1069–1084 (2023). 5. Kosiborod, M. N. et al. N. Engl. J. Med. 390, 1394–1407 (2024) 6. Pandey A., et al. JACC Heart Fail, 13 (2025)	
Novo Nordisk	Guideline and visual summary	025	010	The proposed wording for reviewing medicines is unclear because both sentences convey the same message in reverse. We suggest revising for clarity and consistency as follows: “Consider continuing SGLT-2 inhibitors for their cardiovascular or renal benefits, even if they do not help the person reach their glycaemic or weight targets. Consider continuing GLP-1 receptor agonists for their cardiovascular [or renal] benefits or in early onset type 2 diabetes, even if they do not help the person reach their glycaemic or weight targets.”	Thank you for your comment. In the recommendations for GLP-1 receptor agonists and tirzepatide, the focus is on stopping these medicines if they do not help the person reach their glycaemic or weight targets where people do not have either atherosclerotic cardiovascular disease or early-onset type 2 diabetes, as the cardiovascular benefits of these drugs are less clear outside these populations. This is different from the recommendation for continuing SGLT-2 inhibitors, where cardiovascular and renal benefits are more established in all people with type 2 diabetes.
Novo Nordisk	Health economic analysis	025	004-015	The inputs and assumptions used in the economic model underestimate the weight loss benefits of GLP-1 receptor agonists Weight changes over time are not supported by evidence The assumption of increased weight while still receiving initial therapies is not aligned with the trial	Thank you for your comment. A sensitivity analysis was conducted where it was assumed that the weight effects of all interventions persisted for a lifetime, even where treatment were discontinued. While this resulted in a reduced ICER in interventions that caused weight loss, the difference from the base case was not substantial enough to alter decisions.

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				evidence. While weight has been shown to increase when GLP-1 receptor agonist therapy is stopped, all evidence from long-term trials such as FLOW and SUSTAIN 6 suggest that weight reductions are maintained while treatment is continued (as is the case in the modelling analysis). Maintaining differences in weight and the subsequent quality of life difference could have a substantial impact on the analysis. Furthermore, the methods used to calculate weight change between years 2-4 based on CPRD AURUM data have not been clearly described (Economic Report, pages 24–25). No information is provided on sample size or uncertainty, and it is unclear whether treatment discontinuation has been accounted for. Applying CPRD observational estimates after NMA-derived treatment effects creates uncertainty as this mixes data sources with different underlying assumptions. Furthermore, the methods appear to assume uniform weight trajectories across all patients, despite evidence that weight loss varies by baseline characteristics, presence of comorbidities, and drug classes. The conservative weight rebound assumptions applied following year 4 in the economic model are not evidence based and erroneously favour weight loss for SGLT-2 inhibitors (Economic Report, page	

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				25, lines 4-15). The economic model assumes GLP-1 receptor agonist weight loss benefits are lost within 1 year, whereas SGLT-2 inhibitors are assumed to have a more gradual weight rebound over two years. This weight rebound assumption disproportionately erodes GLP-1 receptor agonist weight loss benefits without clear rationale or empirical justification. Based on the limited evidence for weight loss in people with type 2 diabetes, combination of heterogeneous evidence sources, and application of implausible weight rebound assumptions, the economic model does not appropriately capture the weight loss benefits of GLP-1 receptor agonists versus comparator therapies. The conservative weight loss inputs and assumptions for GLP-1 receptor agonists directly result in their cost-effectiveness being underestimated across all populations in the economic model. Novo Nordisk recommend that consistent weight rebound assumptions are applied for SGLT-2 inhibitors and GLP-1 receptor agonists in the absence of data to support the contrary.	
Novo Nordisk	Guideline and visual summary	027	001	Novo Nordisk welcomes NICE's recommendation of considering subcutaneous semaglutide for adults with type 2 diabetes and heart failure. This recommendation reflects the	Thank you for your comment. Evidence from the Sustain 6, SOUL, FLOW was included in the evidence review. The recommendation for subcutaneous semaglutide and heart failure has now been removed as the dose used in the STEP-

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				large body of evidence highlighting the benefits of semaglutide in this cohort. Novo Nordisk believes that restriction to those living with obesity in the current recommendation excludes a significant number of patients with type 2 diabetes and heart failure. We therefore request that the committee consider amending recommendation 1.8.47 to reflect the evidence provided below in this population (<i>proposed changes in italics</i>): 1.8.47 Consider adding subcutaneous semaglutide for adults with type 2 diabetes and heart failure ~~who need further medicines to reach their weight management targets~~, if: they are living with <i>overweight</i> or obesity there are no concerns about frailty that may increase the risk of adverse events with the medicine they have a preserved ejection fraction. [2025] Rationale Although type 2 diabetes and heart failure are each individually associated with considerable morbidity and mortality, they often occur together, which further worsens adverse patient outcomes, quality of life, and costs of care. Adopting a holistic	HFpEF DM trial was the dose for weight management (2.4 mg weekly) and in balancing the factors together, it was agreed that further evidence was required before making a specific recommendation for people with heart failure. However, people with heart failure living with obesity (the population seen in the STEP-HFpEF DM trial) would be able to access GLP-1 receptor agonists or tirzepatide through the recommendations for people living with obesity if this comorbidity is prioritised when considering therapies for further management of glycaemia if there are no reasons for them take a GLP-1 receptor agonist or tirzepatide..

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				approach for patients living with type 2 diabetes and heart failure is critical to improving outcomes in this high-risk population. Semaglutide has been shown to provide multiple health benefits in this population, beyond weight loss, which include: ➤ Substantial reductions in the risk of heart failure events and cardiovascular mortality. ➤ Cardiovascular protection ➤ Renal risk reduction ➤ Clinically relevant improvements of glycaemic control Summary of clinical evidence for semaglutide in type 2 diabetes and heart failure ➤ SUSTAIN 6¹ and SOUL² demonstrated that semaglutide reduces MACE (non-fatal MI, stroke, and cardiovascular death), in individuals with type 2 diabetes and cardiovascular disease. Considering that 23% of participants in both trials had heart failure at baseline and no BMI cut off for inclusion, the effect on MACE was consistent regardless of baseline BMI. ➤ The FLOW³ trial, which enrolled 3533 participants with type 2 diabetes and chronic kidney disease included 19% participants with heart failure at baseline. This trial demonstrated that semaglutide	

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				reduced the incidence of major kidney disease events by 24%. There was no BMI threshold for inclusion in the FLOW trial. There was no indication of heterogeneity in the effect of semaglutide on the renal outcomes across baseline all BMI subgroups. • A prespecified analysis of the FLOW trial by Pratley <i>et al.</i> examined the effects of semaglutide, on heart failure outcomes in individuals with type 2 diabetes and chronic kidney disease.⁴ The study demonstrated that semaglutide substantially reduces the risk of heart failure events, cardiovascular death, and the composite of heart failure events or cardiovascular death. The benefits of semaglutide on the composite outcome of heart failure events or cardiovascular death were consistent across different BMI subgroups: ▪ BMI ≤30: hazard ratio 0.71 (0.52-0.96)	

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				▪ BMI >30: hazard ratio 0.75 (0.60-0.93) ➤ The STEP HFpEF DM⁵ trial further demonstrated semaglutide's benefits on functional symptoms and physical limitations in patients with T2D and obesity-related heart failure with preserved ejection fraction (HFpEF). Over a 52-week period, patients receiving once-weekly semaglutide (2.4 mg) showed significantly greater improvements in the Kansas City Cardiomyopathy Questionnaire Clinical Summary Score (KCCQ-CSS), which measures HF-related symptoms (estimated difference, 7.3 points; $p < 0.001$) and achieved more substantial weight reduction compared to placebo (estimated difference, 6.4%; $p < 0.001$).⁵ These additional heart failure specific QoL benefits are not captured in the NG28 model which may underestimate the clinical benefit and cost-effectiveness of s.c semaglutide. ➤ Despite the established link between higher BMI and lower B-Type Natriuretic Peptide (NT-proBNP) levels and previous observations suggesting that NT-proBNP	

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				levels increase with weight loss, in patients with T2D and a normal NT-proBNP level at baseline there was a greater reduction in NT-proBNP level with semaglutide than in placebo in STEP HFpEF studies.^{5,6} This is further evidence of the benefits of semaglutide beyond weight-loss. Frailty and effects of semaglutide in heart failure Pandey <i>et al.</i> recently analysed the effects of semaglutide in patients with obesity-related HFpEF, focusing on safety, efficacy and impact on frailty. Using data from the STEP-HFpEF and STEP-HFpEF DM trials^{5,6}, the authors created a frailty index and stratified 1,145 patients into three groups (non-frail, more-frail, and most-frail). They found that semaglutide consistently reduced weight across all groups, but improvements in heart failure symptoms and physical function were greatest in the most-frail patients.⁷ Additionally, semaglutide (vs placebo) reduced the burden of frailty during follow-up with a greater increase in the proportion of non-frail participants and a concurrent decrease in the proportion of more frail and most frail participants at weeks 20	

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				and 52. Semaglutide was also associated with fewer serious adverse events. These findings suggest that frail heart failure patients may benefit from semaglutide, supporting its use regardless of frailty status.⁷ Summary Semaglutide has been shown to provide multiple benefits, beyond weight loss, which makes it a valuable treatment option for people with type 2 diabetes and heart failure. These benefits include: ➤ Significant reductions in the risk of heart failure events and cardiovascular mortality ➤ Improvement in heart failure-related symptoms & physical function ➤ Significant reduction in major cardiovascular adverse events ➤ Reduction in major kidney disease events ➤ Clinically relevant improvements in glycaemic control References 1. Marso, S. P. <i>et al.</i> N Engl J Med 375, 1834-1844, doi:10.1056/NEJMoa1607141 (2016). 2. McGuire D <i>et al.</i> N Engl J Med. 2025;392:2001–12	

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				3. Perkovic V, <i>et al.</i> N Engl J Med. 2024: DOI: 10.1056/NEJMoa2403347 4. Pratley RE, <i>et al.</i> J Am Coll Cardiol. 2024;84(17):1615–1628. doi: 10.1016/j.jacc.2024.08.004 43. 5. Kosiborod, M. N. <i>et al.</i> N. Engl. J. Med. 390, 1394–1407 (2024) 6. Kosiborod, M. N. <i>et al.</i> N. Engl. J. Med. 389, 1069–1084 (2023) 7. Pandey A., <i>et al.</i> JACC Heart Fail, 13 (2025)	
Novo Nordisk	Health economic analysis	028	Table 014	The choice of input value for the stroke treatment effect for subcutaneous semaglutide in the chronic kidney disease (CKD) subpopulations is questionable and should be reconsidered. There is substantial uncertainty in the stroke hazard ratio which was sourced from FLOW. This study was designed and powered to investigate major kidney disease events and stroke hazard ratio is derived from a small number of stroke events. In the CKD population, the stroke hazard ratios from FLOW were directly included in the economic model, bypassing NMAs. This introduces significant uncertainty due to several concerns:	Thank you for your comment. The committee made a priori decision to apply a set of hierarchical rules to determine which treatment effects should be included or excluded in the health economic model, and how these effects should be carried over across different populations. They agreed that maintaining transparent decision rules was preferable, since it helps minimise bias and ensures consistency in the modelling process. The committee revisited their position following consultation and decided to reaffirm their original position..

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				• Lack of face validity: The stroke hazard ratio (HR) from FLOW (1.22) suggests increased stroke risk with s.c semaglutide in CKD, contrasting sharply with the HR used in non-CKD populations (0.62) and other GLP-1 receptor agonists (0.78–0.88), which indicate reduced stroke risk. • Contradictory evidence: The evidence for semaglutide including clinical trials (e.g. SUSTAIN-6) suggest that semaglutide decreases the risk of stroke. • Limited data: The stroke HR from FLOW is based on few events and wide credible intervals (1.22 [0.84–1.77]), from a trial not powered for cardiovascular outcomes. • Inconsistent inclusion criteria: Similar or narrower credible intervals from NMAs were excluded, yet the FLOW HR was included. • Modelling limitations: The economic model does not account for uncertainty around point estimates, potentially skewing cost-effectiveness results. Given that stroke is a key driver of cost-effectiveness, the source of the FLOW stroke hazard ratio undermines the reliability of the model and should be reconsidered. An	

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				alternative which would be more aligned with the other comparators in the analysis would be to use the cardiovascular event treatment effects from the ASCVD subpopulation, which are taken from studies more focused on cardiovascular events, to inform the cardiovascular event treatment effects in the CKD subpopulation.	
Novo Nordisk	Committee Discussion	033	1.5.2.2	[This text was identified as confidential and has been removed]	Thank you for your comment
Novo Nordisk	Guideline	033	012	Insulin recommendations Regarding the recommendations for choosing a type of insulin, Novo Nordisk welcome that the current draft guideline wording affords a level of flexibility that will allow prescribers to account for a person's individual needs and preferences.	Thank you for your comment.
Novo Nordisk	Health economic analysis and Excel file NG28 T2DM model BASECAS E v1	041	Paragraph titled "Weight"	The quality of life of being at a lower weight in year 5+ associated with GLP-1 receptor agonists is underestimated The conventional approach when using the Bagust and Beale disutility is to reflect the utility impact of a BMI > 25 kg/m ² . Therefore, the calculation in each	Thank you for your comment. We have updated the analysis in accordance with your suggestion. Although this led to an improved ICER for weight-reducing interventions, the overall conclusions remain unchanged. In the sensitivity analysis where weight-related treatment effects were assumed to persist for a lifetime, the ICER for SGLT-2 inhibitors decreased to £14,363 from a base case ICER of £15,152, while the ICERs for GLP-1 receptor agonists

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				year of the analysis is IF (current BMI > 25, (current BMI - 25) * -0.0061, 0). Instead, the utility has been applied to the change in the previous year (BMI in year n – BMI in year n-1) * -0.0061. In years 5+, BMI is tracking parallel with all interventions but is notably lower with GLP-1 receptor agonists. However, no utility benefit associated with being at lower weight is captured, underestimating the quality-adjusted life expectancy associated with GLP-1 receptor agonists in the base case analyses. This is likely to be having an even greater impact in the sensitivity analyses where differences in weight are maintained over patient lifetimes. Therefore, NN recommend that the utility applied in year 5+ be revised to ensure that the utility benefit associated with a lower weight for those on GLP-1 receptor agonists is captured. References	ranged from £11,449 to £29,184 (base case ICERs ranged from £12,515 to £30,911).

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				Bagust A, Beale S. Modelling EuroQol health-related utility values for diabetic complications from CODE-2 data. Health Economics. 2005;14(3):217-30.	
Novo Nordisk	Guideline	066	015	[This text was identified as confidential and has been removed]	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Novo Nordisk	Health economic analysis	101	011-015	The cost-effectiveness of oral semaglutide is significantly underestimated across all populations and key SOUL clinical trial data should be incorporated into the economic analysis Lines 11-15 state that no evidence was identified in the clinical review to inform several cardiovascular treatment effects for oral semaglutide—specifically IHD, HHF, MI, stroke, or ESKD. As a result, the	Thank you for your comment. The SOUL study has now been incorporated into the guideline review network meta-analysis. However, its inclusion did not alter the NMA outcomes.

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				economic model assumes no treatment effect (hazard ratio = 1) for these outcomes. The Committee views this as a key limitation, noting that benefits seen with other GLP-1 receptor agonists are likely apply to oral semaglutide as well. Therefore, the model likely underestimates its effectiveness and cost-effectiveness. Novo Nordisk agrees with this assessment. In March 2025, the SOUL trial was published by McGuire <i>et al.</i>, providing relevant CVOT data for oral semaglutide in a large type 2 diabetes population. While these data may have been missed in the initial review, Novo Nordisk believes SOUL helps address the Committee's concerns. Therefore, inclusion of the SOUL trial cardiovascular hazard ratios for oral semaglutide should be considered to both keep consistency in the economic methods and address the limitations raised by the Committee. The SOUL publication can be found at: https://www.nejm.org/doi/abs/10.1056/NEJMoa2501006 References	

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Oviva UK	Visual summary	001		If the person has reached their glycaemic and weight targets, 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 glycaemic or weight targets. If patients remain on these meds due to positive impact on weight, CV and renal benefits and achieve an HbA1C <48 will they be coded as being in remission from Diabetes? Is the definition of remission still fit for purpose.	Thank you for your comment. The definition of remission in type 2 diabetes is beyond the scope of the guideline.
Oviva UK	Visual summary	001		Diet and behaviour change referenced – should physical activity/movement be also referenced here	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline
Oviva UK	Guideline	007	019	Initial body weight loss target of 5-10% recommended. No discussion of the importance and benefit of the maintenance of this weight loss.	Thank you for your comment. This is out of scope for the guideline update.

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Oviva UK	Guideline	011	021	With the increased and earlier prescribing of SGLT-2 inhibitors should patients have the ability to test for ketones?	Thank you for your comment. This section is out of scope for the guideline update.
Oviva UK	Guideline	022	014	Are these personal set goals, or general guidance of xx% at 16 weeks like national weight loss medication guidance	Thank you for your comment. These are individualised goals. This has been clarified in the guideline.
Oviva UK	Guideline	039	016	'healthy living' referenced but not defined in glossary?	Thank you for your comment. A link has now been added to the guidelines to the NHS better health website which offers guidance on healthy living
Oviva UK	Guideline	041	013	Research into the risk of ketones if using TDR alongside SGLT-2 inhibitors? Potential for a medication adjustment guidance update for those referred to T2DR on an SGLT-2 and potential increase in access for those who are taking SGLT-2 for cardiovascular benefit but would still like to aim for diabetes remission	Thank you for your comment. This topic is out of scope for the guideline update and we did not review evidence on total diet replacement alongside SGLT-2 inhibitor use so we are unable to make a research recommendation this. We will pass on this comment to our surveillance team for consideration as part of any future updates.
Oviva UK	Guideline	057	015	Lifestyle and behavioural support: Trial outcomes with GLP-1 agonists were achieved alongside structured diet and lifestyle support, yet this is not acknowledged in the document. Specific guidance should include recommendations such as: • 500 kcal/day energy deficit • Emphasis on protein and fibre intake • Strength/resistance exercise to preserve muscle mass	Thank you for your comment. The recommendations are built on the rest of the recommendations in the guideline, such as recommendation 1.3.5 in the consultation version of the guideline that recommends that dietary advice, physical activity and weight management advice should all be a part of support provided to people with type 2 diabetes. Following consultation, we have also added a new recommendation to state that dietary advice and other aspects of healthy living such as physical activity should be used alongside medicines and have referred to the NHS Type 2 diabetes Path to Remission Programme, the NICE guideline on overweight and obesity management and the NHS Better Health website. We

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				Ongoing behavioural support to maintain outcomes	are unable to include additional information based on the scope of this guideline update which was only to update the guidance on medicines
Pharmacists' Defence Association	Resource impact template (excel sheet)	General		Th Guideline Scope under the title "Settings" on page 3 says "All settings where NHS-funded care is provided." Pharmacists practice in community pharmacies, in GP surgeries and hospitals. In all three settings there is likely to be a resource impact on pharmacists, with the greater burden falling on primary care pharmacists and community pharmacists. The Draft Resource Impact template worksheet "capacity impact" only calculates for GLP1 and there is no provision for SGLT2 medicines. Firstly, community pharmacy premises are NHS settings and are funded by the NHS to provide dispensing and other clinical services under the supervision of pharmacists. Changes in prescribing formularies or guidelines can have significant impact on community pharmacists and pharmacy operations.	Thank you for your comment. Feedback for starting SGLT-2 inhibitor treatment stated with it being an oral treatment there is no additional GP appointment required compared with what is happening with metformin alone. didn't require more than what would be happening with metformin alone.

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				https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/nhs-new-medicine-service/ All community pharmacies in England provide a service call “New Medicines Service” (NMS) and this requires pharmacists, with patient consent, to increase effective medicine taking for the treatment of a long-term condition. Medicines dispensed in community pharmacy for Type 2 Diabetes including SGLT2 and GLP1 come within the scope of the NMS. Pharmacists will engage with patients and initial advice will be given to the patient about the medicine and its use. Subsequent interventions, either remotely or in person will take place to enable the pharmacist to assess the patient's adherence to the medicine(s), identify problems and determine the patient's need for further information and support. In England, approximately one million NMS interventions occur every month (source NHSBSA monthly contractor data). The time taken for initial engagement and subsequent interventions (remotely or in person) would likely total around 30 minutes per patient. Pharmacy operators are paid £28 per completed NMS.	

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				It is unclear how any impact on community pharmacy has been provided for within these guidelines. Secondly, pharmacists in primary care often “manage” medicines for cohorts of diabetic patients. Pharmacists may make decisions around the patients’ medication based on the results of diagnostic tests, for example blood test results and there seems to be no provision for the capacity impact of extra blood tests (including assessing the subsequent results) for either SGLT2 or GLP1 medications. The total capacity impact may likely be greater than that assumed in the worksheet. Overall, whilst we welcome this update, but we are concerned about the assessment of the impact in practice, and capacity assumptions especially given the large number patients that may be affected.	
Pharmacists’ Defence Association	Resource impact template (excel sheet)	General		Physical availability of medicines. It is unclear if there has been consideration of the availability of the physical supply of medications. There have been multiple occasions in the recent past around medicine shortages, and it is unclear if	Thank you for your comment. NICE makes recommendations based on effectiveness and cost-effectiveness evidence.

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				any change in guidance could potentially cause a supply issue if plans are introduced at scale. The NHS 10-year plan proposes a national formulary, and it is not clear whether this would have an impact on the implementation of this guideline.	
PrescQIPP CIC	Consultation questions		001	1. Would it be challenging to implement any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiative.). Given the very large numbers of patients who this guideline will apply to, the resources needed to review all patients will be significant and will put pressure on already overstretched primary care services. We are concerned about large numbers of patients being able to understand the logistics of safely starting two, and in some cases three, medicines prescribed on the same prescription, but to be started sequentially. We suggest nationally agreed resources including a patient information leaflet to support this would be helpful.	Thank you for your comment. We acknowledge and agree with this. At the same time, given that diabetes is a long-term condition, providing the treatments described will reduce the likelihood of developing long-term conditions. These will require more care and appointments long-term leading to more pressure on the system. Given this, we believe that there are benefits to providing and implementing this guidance. We acknowledge the challenges in starting multiple medicines sequentially. NICE is considering developing a clinician discussion aid to help support implementation of this.
PrescQIPP CIC	Consultation questions		002	2. Would implementation of any of the draft recommendations have significant cost implications?	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day

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				Prescribing SGLT-2 inhibitors and GLP-1 receptor agonists for the wide patient cohorts proposed in the draft guidance would have significant cost implications. It is important that the guidelines clearly states that only medicines that have been demonstrated to be cost effective should be used for example, generic dapagliflozin.	to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
PrescQIPP CIC	Consultatio n questions		003	3. Should NICE update the existing technology appraisals for canagliflozin, dapagliflozin, empagliflozin, and ertugliflozin (TA288, TA315, TA336, TA390, TA418, TA572, TA583)? If so, please provide a rationale for this. Details of the update process are in NICE health technology	Thank you for your comment. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal

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				evaluations: the manual, see 8.4 Surveillance decision options. We believe that all existing related NICE guidance should be reviewed and retired if recommendations are out of date. There is currently a bewildering array of guidance relating to type 2 diabetes and associated co-morbidities. For example, there are at least 14 NICE TAs relating to SGLT-2 inhibitors. As commissioners have a statutory duty to commission medicines in line with NICE TAs, a comprehensive review of all NICE TAs and guidance in this area is needed, and TAs retired if they are no longer recommending medicines use in line with current evidence and best practice.	regarding the update of the relevant SGLT2 inhibitor technology appraisals.
PrescQIPP CIC	Guideline	General		We recognise the need for and welcome new guidelines on the management of adults with Type 2 diabetes. However, we are concerned that the committee discussions and information in the health inequalities document do not always support the conclusions and recommendations made. We are also concerned that the recommendations in the guidance do not align with other NICE guidance such as NG246 Overweight and obesity management, and NICE TAs for specific medicines.	Thank you for your comment. When developing NICE guidelines, the committee considers the evidence in combination with their expertise to develop the recommendations, the committee discussion is a summary of this. Other sections of the evidence review such as the summary of effectiveness evidence provide details on individual studies and results included in this review that contributed to the evidence. The committee takes into account health inequalities when making the recommendations to make sure any inequalities are not exacerbated or created. In some situations, the committee will make recommendations for specific health inequalities such as the recommendation on

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				There is currently a bewildering array of guidance relating to type 2 diabetes and associated co-morbidities. For example, there are at least 14 NICE TAs relating to SGLT-2 inhibitors. As commissioners have a statutory duty to commission medicines in line with NICE TAs, a comprehensive review of all NICE TAs and guidance in this area is needed, and TAs retired if they are no longer recommending medicines use in line with current evidence and best practice. Clarity is needed throughout the guidance on the use of the term 'GLP1'. Tirzepatide is a dual incretin agonist (acts as both a GIP and GLP-1 receptor agonist), and it needs to be very clear in the guideline that 'GLP1' does not mean tirzepatide. This is acknowledged in the recommended pathway position of tirzepatide as stated in TA924. We have concerns over the widespread recommendations for the use of SGLT-2 inhibitors in this guideline as the evidence does not appear to support this use in several of the recommended groups. Page 24 on the Health Inequalities briefing states "For individuals with T2DM, high risk of developing CVD and who are overweight, those with early	addressing health inequalities in SGLT-2 inhibitor access and uptake. Regarding alignment with other guidance. The aim of the type 2 diabetes guideline is to provide guidance for people where the aim for treatment is primarily for cardiovascular and renal protection and glycaemic benefit. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this. Regarding the term 'GLP1', we have now added the term 'GLP-1 receptor agonist and dual agonists' which is defined in the guideline and makes it clear where the place for tirzepatide is in the guideline. Regarding the use of SGLT-2 inhibitors, we believe that this has been recommended where appropriate. Please see other comments that you have asked about this for responses for specific areas. Where you have noted the health inequalities briefing stating variations, please see the rationale and impact sections and committee discussion document for information

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				onset T2DM, those with ASCVD and those with CHF, total net health benefits were negative. Variations across IMD were observed with those who are overweight and those with CHF showing negative net health benefits across all IMD groups. Given that these four groups also had ICERs exceeding the cost effectiveness threshold, providing SGLT-2 inhibitors for these populations would not represent good value for money". This is in conflict with the draft guideline which is recommending the use of SGLT-2 inhibitors in all patient groups. Given the very large numbers of patients that this guidance will apply to, the side effect burden and cost to the system, we question if it is reasonable to offer SGLT-2 inhibitors to patient groups where the clinical evidence and cost effectiveness is weak. The draft guidance focusses on the potential benefits of treatment, but we believe it should make the risks of treatment, particularly with SGLT-2 inhibitors and GLP-1 receptor agonists, clearer to clinicians and patients. This includes potential side effects for example, fungal infections and UTIs, which are a major problem with these medicines in practice especially in older frail patients, and genital infections, balanoposthitis, and phimosis resulting in	about why the medicine has been recommended in each situation. The committee took into account the benefits and the risks and agreed that the recommendation was appropriate. Prescribers are expected to understand the BNF and product characteristics for the medicines that they are prescribing, which state about the adverse events from the treatment. We agree that selecting the most cost effective therapy is a clinical reality which is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices).

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				an increase in the number of circumcisions in older male patients. We believe that a specific patient focussed Patient Decision Aid which clearly sets out the relative risks and benefits of treatment is needed to support shared decision making. The committee discussion acknowledges reservations about the cost effectiveness of SGLT-2 inhibitors, apart from generic dapagliflozin. The guidance should clearly state that generic SGLT-2 inhibitor formulations only should be used. Currently only dapagliflozin is available generically but the use of the blanket term 'generic SGLT-2 inhibitors' will future proof the guideline should other SGLT-2 inhibitors become available as generics in the future. A statement should be included that the most cost effective GLP-1 formulation that is clinically appropriate for the patient should be used where indicated. This should allow for the use of generic liraglutide, where clinically indicated and appropriate in the first instance. It should be formally noted that the use of semaglutide in the management of type 2 diabetes is not currently subject to a positive NICE TA recommendation.	In the case of liraglutide, this was shown to not be clinically effective at providing cardiovascular and renal protection and reducing weight, so compared to other GLP-1 receptor agonists this may not be the most clinically appropriate medicine for some people. Therefore, this is an important distinction. We do not need to formally note that semaglutide is not subject to a technology appraisal recommendation. This is not done in other circumstances. We appreciate the feedback about guidance for the optimum management of interconnected cardiovascular renal metabolic conditions. This will be fed back to our surveillance team for consideration in potential updates. We agree that there is value in a patient decision aid in this area. NICE is considering developing a clinical discussion aid to accompany the guideline to help with this.

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				In addition to this guideline, we believe that dedicated, clear guidance for the optimum management of interconnected cardiovascular renal metabolic conditions is needed.	
PrescQIPP CIC	Guideline	014	016	We suggest that a statement should be included that the drug with the lowest acquisition cost that is clinically appropriate for the patient should be used.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors

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					and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
PrescQIPP CIC	Guideline	014	018	Clarity is needed throughout the guidance on the use of the term 'GLP1'. Tirzepatide is a GIP and GLP-1 receptor agonist, and the committee need to make it very clear in the guideline that 'GLP1' does not mean tirzepatide. A statement should be included that the most cost effective GLP-1 formulation that is clinically appropriate for the patient is used.	Thank you for your comment. The term 'GLP-1 receptor agonists and tirzepatide' is now used in the guideline where appropriate, to reflect where this includes tirzepatide and 'GLP-1 receptor agonist' alone is used when this only refers to GLP-1 mono-receptor agonists. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally

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					suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
PrescQIPP CIC	Guideline	015	001	We believe it is vital that patients are given clear evidence based information on the relative benefits and risks of treatment. SGLT-2 inhibitors and GLP-1 receptor agonists are not innocuous medicines with limited adverse drug reactions like metformin and gliptins. The focus of this guideline is on the potential benefits, and we do not feel that it sufficiently highlights the risk of harm associated with these medicines. We believe that a specific patient focussed Patient Decision Aid would be beneficial to support shared decision making. It would also be useful for the guidance to signpost to other resources e.g. GPevidence.org. to give the patient and the clinician an understanding of the absolute benefits and harms of each medicine. For example: If 100 people with newly diagnosed type 2 diabetes take metformin for 10 years, 7 will avoid death compared to those who do not take metformin.	Thank you for your comment. We completely agree with you. The adverse events from SGLT-2 inhibitors and GLP-1 receptor agonists should be taken into accounts (as should metformin and DPP-4 inhibitors, though we acknowledge the risks are lower). Guidance on what these are is available in the BNF and SPC for each medicine and this is referred to in the guideline. We agree about highlighting the benefits against the harms. For example: the risk of dying from cardiovascular causes from diabetes is 61 in 1000 according to our review, taking an SGLT-2 inhibitor can reduce this by 3 to 22 in 1000 over 3 years according to our review, while the risk of Fournier's gangrene and diabetic ketoacidosis is between 1 in 1000 and 1 in 10,000 according to the BNF. This should be balanced against the risk of less severe genitourinary infections which occurs in around 10 in 1000 to 100 in 1000. NICE is considering developing a clinical discussion aid to accompany the guideline to help with this. Thank you for highlighting your concern.

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				Whereas, if 100 people with type 2 diabetes (without existing CVD) take an SGLT-2 inhibitor for 4 years, none of them will have a difference in MI, stroke or death. Or, if 100 people with type 2 diabetes (with existing CVD) take an SGLT-2 inhibitor for 4 years, 0.8 will avoid death compared with those who do not take an SGLT-2 inhibitor.	
PrescQIPP CIC	Guideline	015	002	Whilst we have concerns about the included recommendations themselves, we think the visual summary could be an extremely useful tool.	Thank you for your comment.
PrescQIPP CIC	Guideline	017	012	The NICE guideline states: 'In this guideline, SGLT-2 inhibitors and GLP-1 receptor agonists are recommended as much for their cardiovascular benefits as for their glycaemic benefits (unless otherwise specified). Healthcare professionals should also refer to the summary of product characteristics for individual medicines for contraindications and precautions to take in pregnancy and for women, trans men and non-binary people of childbearing potential.' While we accept that there is evidence to support this statement, in studies the cardiovascular benefits were seen in patients at highest risk. There is currently no evidence to support whether these benefits will extrapolate to the wider diabetes population.	Thank you for your comment. Study populations were defined as having high cardiovascular risk if they had a QRISK2 score more than 10% in adults aged 40 years and older, or an elevated lifetime risk of cardiovascular disease defined as the presence of 1 or more cardiovascular factors in someone under 40 years. When extracting data for the reviews, it was uncommon for studies to report baseline QRISK scores, and so a pragmatic decision was made assign these studies to the high cardiovascular risk population on the basis that diabetes is a major risk factor for cardiovascular disease, and it was likely that the study populations would be at high cardiovascular risk due to diabetes alone. Consequently, no evidence was identified for people with diabetes and low cardiovascular risk (model 4). Therefore, the study populations in model 5 (diabetes and high cardiovascular risk) are likely to represent the wider diabetes population since all people with

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					type 2 diabetes are at higher risk for cardiovascular disease than those without
PrescQIPP CIC	Guideline	018	004	The NICE committee discussion states 'No evidence was identified for people with type 2 diabetes and a low risk of cardiovascular disease. Cardiovascular risk rises with age, and even without any other risk factors QRISK3 classes people with type 2 diabetes as at high cardiovascular risk at age 52 (for men) and age 60 (for women).' Additionally, although rare, SGLT-2 inhibitors are associated with serious side effects, i.e. risk of diabetic ketoacidosis and Fournier's gangrene, that have been subject to MHRA patient safety alerts. We therefore question if it reasonable and cost effective to start all patients with T2D and a low risk of cardiovascular disease on an SGLT-2 inhibitor? As patients should be reviewed annually, we suggest these drugs should be started only when indicated i.e. when the patient's risk rises.	Thank you for your comment. We have added more information to the rationale regarding people with type 2 diabetes increased lifetime risk of cardiovascular disease compared to those people without diabetes and the benefits of taking an SGLT-2 inhibitor to aid risk reduction. The committee agree that no person with type 2 diabetes is truly at low risk of cardiovascular disease (some may be at lower risk relative to others, but all have a high level of lifetime risk of developing cardiovascular disease). We acknowledge the increased risk of side effects. However, when balanced against the benefits we agreed that the benefits outweigh the potential harms. Benefits were seen in reducing the number of people dying from cardiovascular disease, having a heart attack or a stroke (3-item MACE) and hospitalisation for heart failure. 123 out of 1000 people have a 3-item MACE event over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by 8 to 16 people if an SGLT-2 inhibitor is used for 3 years. Meanwhile, 54 out of 1000 people are hospitalised with heart failure over 3 years in the evidence when they do not have an SGLT-2 inhibitor. This reduced by 14 to 28 people if an SGLT-2 inhibitor is used for 3 years. These clinically important reductions were weighed against the chance that 10 to 100 in 1000 people would experience genital infections and 1 in 1000 to 1 in 10,000 people would experience rarer events like diabetic ketoacidosis

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					or Fournier's gangrene or severe infections. Given this, the committee agreed that in most cases the benefits outweighed the risks. They agreed that the risk of volume depletion is manageable, and that it would be uncommon for it to lead to diabetic ketoacidosis. They noted that these risks should be discussed with the person ahead of starting treatment. Furthermore, the committee agreed the benefits to reducing inequalities in providing SGLT-2 inhibitors and metformin as a part of standard therapy for most people with type 2 diabetes. Health inequalities have been highlighted that show that providing SGLT-2 inhibitors will provide net health benefits for people living in the lowest two quintiles of the index of multiple deprivation. By implementing this recommendation on a population level, where the default position is to provide the treatment and consider the exceptions where you should not, this will help to reduce health inequalities and ensure that the health of the whole population improves, reducing deaths, cardiovascular events, renal disease and glycaemic complications. Providing that option to people with type 2 diabetes is clinically and cost-effective and we believe that supporting people with diabetes to decide if this is best for them will lead to better outcomes long term.
PrescQIPP CIC	Guideline	019	009	The fact that currently there is no positive NICE TA for the use of semaglutide in the treatment of T2D in adults is problematic. Commissioners are	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and

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				mandated to commission the use of medicines in line with NICE TAs, and are not legally required to follow NICE guidance. This may result in variation in uptake of these guidelines and subsequent inequalities in access to treatment.	leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease. The recommendations written apply to services across England and Wales. We recommend that steps are taken to reduce inequity in access where this can be predicted and identified.
PrescQIPP CIC	Guideline	020	005	For patients with existing atherosclerotic cardiovascular disease, the committee discussion states that subcutaneous semaglutide is the only GLP-1 agonist that is cost effective. However, in this section it implies that any GLP-1 agonist can be prescribed with the aim to reduce CVD in the long term. This appears to be illogical and needs clarification.	Thank you for your comment. For those people with atherosclerotic cardiovascular disease and type 2 diabetes, out of the GLP-1 receptor agonists and tirzepatide only subcutaneous semaglutide showed clinically important evidence of cardiovascular and renal protection and glycaemic benefits alongside a potentially beneficial weight reduction side effect while also being cost effective for people with atherosclerotic cardiovascular disease. However, as noted in the committee discussion and rationale, no treatments are cost effective for people with early-onset type 2 diabetes. Due to this, recommending one GLP-1 receptor agonist or tirzepatide over any other would not be logical. Therefore, the committee made a class-level recommendation in this population. We did not find any specific evidence for adults 18 to 25 years that met our review protocol. The committee identified this as a gap in the evidence and therefore made a research recommendation around treatments for people with early-onset type 2 diabetes.

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PrescQIPP CIC	Guideline	020	015	It seems illogical that a person with early onset T2D (who is very likely to be living with obesity) may be considered for a GLP-1 agonist, yet a person with T2D living with obesity (without early onset) will not be. The potential conflict with the eligibility criteria for GLP-1 agonists for weight loss only is understandable, but makes this guidance inconsistent.	Thank you for your comment. We agree that this has been confusing and have added extra detail into the guideline and rationale to make this clearer. People with early onset type 2 diabetes have a higher lifetime risk of developing cardiovascular and renal disease than people with later onset type 2 diabetes. While they could also be living with obesity (as you state, the chances of also living with obesity are higher in this group), the benefits from a GLP-1 receptor agonist or tirzepatide are primarily to provide heightened cardiovascular and renal protection and glycaemic reductions in this case. Weight reduction is noted as a potentially beneficial side effect from the treatment. If weight reduction is a primary treatment aim, guidance can be found in the overweight and obesity management guideline.
PrescQIPP CIC	Guideline	021	012	Given the uncertainty in cost effectiveness of SGLT-2 inhibitors, the guidance should state that only generic SGLT-2 inhibitors licensed for use in CKD should be used.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be

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					considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin). The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m².
PrescQIPP CIC	Guideline	025	015	The guideline should include specific targets e.g. percentage weight loss or HbA1c reduction within a certain time-frame. For example section 1.7.22 in the current guideline states: Only continue GLP-1 mimetic therapy if the adult with type 2 diabetes has had a beneficial metabolic response (a reduction of at least 11 mmol/mol [1.0%] in HbA1c and weight loss of at least 3% of initial body weight in 6 months). [2015]	Thank you for your comment. Wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes.
PrescQIPP CIC	Guideline	025	021	We agree that this is an important statement and that existing patients receiving them concurrently should be identified and reviewed.	Thank you for your comment.

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PrescQIPP CIC	Guideline	027	001	We think this section should be headed 'People with heart failure with preserved ejection fraction' rather than specifying this in bullet point, line 8.	Thank you for your comment. The sections discussing heart failure include both preserved and reduced ejection fraction heart failure. Recommendations discussing subcutaneous semaglutide (where it explicitly states preserved ejection fraction heart failure) were the only ones that only apply to a specific type of heart failure. They have since been removed. This has been clarified in the section titles.
PrescQIPP CIC	Guideline	027	008	We think this section should be headed 'People with heart failure with preserved ejection fraction' rather than specifying in this bullet point.	Thank you for your comment. The sections discussing heart failure include both preserved and reduced ejection fraction heart failure. Recommendations discussing subcutaneous semaglutide (where it explicitly states preserved ejection fraction heart failure) were the only ones that only apply to a specific type of heart failure. These have since been removed. This has been clarified in the section titles.
PrescQIPP CIC	Guideline	029	011	The committee discussion includes the following two statements: "Evidence showed that no GLP-1 receptor agonist reached the cost-effectiveness threshold in the base-case analysis for people living with obesity. However, the committee considered sensitivity analyses where the price for liraglutide reduced further following the expiration of the medicine's patent in November 2024. It became cost-effective when the price reduced by 35%. Given this, they agreed that there was potential for GLP-1 receptor 24 agonists to be cost effective under specific circumstances."	Thank you for your comment. We have amended the committee discussion for the second paragraph. The first paragraph was stating that there was a sensitivity analysis where GLP-1 receptor agonists are cost effective when liraglutide has a price reduction but is not making a statement either way about which GLP-1 receptor agonist should be considered, so this does not need adjusting. The committee have recommended that any GLP-1 receptor agonist or tirzepatide can be considered for people in this population given that all available GLP-1 receptor agonists showed glycaemic benefits and some cardiovascular benefits. The most clinically effective was subcutaneous semaglutide which was slightly over the threshold for cost-effectiveness. On

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				and: "Based on the clinical and cost-effectiveness evidence, the committee made a recommendation to offer subcutaneous semaglutide alongside SGLT-2 inhibitors for people with ASCVD and to consider adding it alongside SGLT-2 inhibitors for people with HF and living with obesity if further treatment is needed, in the latter group as a means to reach glycaemic targets". The first comment implies that only generic liraglutide should be considered for this group (as presumably the price drop of liraglutide cannot be extrapolated to all GLP-1 agonists), and the second comment implies that only subcutaneous semaglutide should be considered for this group (based on clinical and cost effectiveness), yet the actual recommendation is "consider adding a GLP-1 agonist", implying that any GLP-1 agonist may be used. We believe that this needs clarification.	the other hand, liraglutide was cost effective but was less clinically effective. Other GLP-1 receptor agonists and formulations of GLP-1 receptor agonists (such as oral semaglutide) were not cost effective and were comparatively less clinically effective. Tirzepatide was shown to be cost effective in the technology appraisal for people with type 2 diabetes but did not have evidence for cardiovascular and renal benefits, which GLP-1 receptor agonists did have. This produced uncertainty in the evidence. Given this, they made a weaker consider recommendation in this case.
PrescQIPP CIC	Guideline	030	016	It needs to be clear throughout the guidance that tirzepatide is a dual incretin agonist (acts as both a GIP and GLP-1 receptor agonist), and that 'GLP1' does not mean tirzepatide. This is acknowledged in the recommended pathway position of tirzepatide as stated in TA924.	Thank you for your comment. The wording discussing GLP-1 receptor agonists has now been changed to say "GLP-1 receptor agonist or tirzepatide" to show the role of tirzepatide in this population. The recommendation about the technology

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				TA924 does not align with this pathway for people with T2D living with obesity. TA924 states tirzepatide is an option if 'triple therapy with metformin and 2 other oral antidiabetic drugs is ineffective, not tolerated or contraindicated'. On this pathway the person will be unlikely to have triple oral therapy - they will be on metformin, SGLT-2i and a GLP-1. Either this guideline pathway or TA924 needs amending so that they align.	appraisal for tirzepatide has been removed as this medicine has now been incorporated into the guideline. The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a review proposal regarding the update of the tirzepatide technology appraisal.(TA924).
PrescQIPP CIC	Guideline	031	020	Given the increased risk of falls and hypoglycaemia, we question if it is appropriate to offer sulphonylureas as a treatment option in patients who are frail.	Thank you for your comment. The risk has been noted in the recommendations and the rationale. The committee believe that there are still circumstances where sulfonylureas can be effective. Equally there are risks with other treatments that are recommended. Balancing the risks against the benefits and considering this with the person with diabetes and coming to a decision together is key to helping the person to make good decisions about their healthcare.
PrescQIPP CIC	Guideline	052	013	The Health Inequalities briefing states that "Raising uptake from 22% to 80% could raise total health benefits from 52,898 QALYs to 192,355 QALYs. However, high opportunity costs (191,706 QALYs) reduce the overall net gains." We therefore think that the overall assumptions about treatment costs being offset may be overstated.	Thank you for your comment. As noted in the guideline document, we recognise that the associated costs of increased uptake of SGLT-2 inhibitors may be partially offset by reductions in future cardio-renal events. The health economic report highlights that while SGLT-2 inhibitors as a class are expected to increase overall costs, they also lead to gains in QALYs. The additional expenditure required to achieve these benefits is within acceptable limits.
PrescQIPP CIC	Guideline	052	024	Whilst current developments in technology allow for medicines to be prescribed and added to patient	Thank you for your comment. We have adjusted the wording to reflect this.

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				record at initial appointment, we have serious concerns around patient safety in practice. It is likely that a significant proportion of patients will not understand how to start their medicines in a sequential manner leading to increased adverse events and wastage. We are concerned about large numbers of patients being able to understand the logistics of safely starting two, and in some cases three, medicines prescribed on the same prescription, but to be started sequentially. We suggest nationally agreed resources including a patient information leaflet to support this would be helpful.	
Primary Care Cardiovascular Society	Guideline	General		As a general comment this draft guideline is very good and captures the changes that need to be reflected in practice for the management of type 2 diabetes	Thank you for your comment. We appreciate your feedback.
Primary Care Cardiovascular Society	Guideline	General		What is the place of oral semaglutide? If this is not recommended in the guidelines add a statement as to why not. It is an option specify when this could be considered as an alternative to subcutaneous (and any pros/cons for this).	Thank you for your comment. It is included in the recommendations that discuss GLP-1 receptor agonists as a class, but not when subcutaneous semaglutide alone is specified as it was not a clinically and cost-effective option for those populations.
Primary Care Cardiovascular Society	Visual summary	002	Column 2	Column2 (and other with the same recommendation) If a GLP-1RA has not been effective it is highly unlikely that a DPP4i will be. Is this recommendation based on that fact that failing with a DPP4i is less expensive than failing with e GLP-1?	Thank you for your comment. Based on the evidence and their own clinical and lived experience, the committee recommended that a DPP-4 inhibitors should be first choice for people who need further medicines. In this instance a DPP-4 inhibitor would be offered only if a GLP-1 receptor agonist is contraindicated, not

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Primary Care Cardiovascular Society	Visual summary	002	Column 3 (and main content)	There is no reason to exclude canagliflozin from the recommended SGLT2i for people with 2DM and CKD. CREDENCE showed evidence of benefit. Is it worth a reminder that SGLT2i have limited impact on glycaemic control as eGFR goes down so other therapies are needed but the SGLT2i should be continued for its renal protective effects	Thank you for your comment. There is now a recommendation for offering any SGLT-2 inhibitor for those with an eGFR above 30 ml/min/1.73 ² . The recommendations in the visual summary have been amended following these changes. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact sections of the guideline
Primary Care Cardiovascular Society	Visual summary	002	Column 4	Does the algorithm need a reminder about why should consider a GLP-1 here?	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact section sir reasons to consider a GLP-1 receptor agonist or tirzepatide for people with early-onset diabetes.
Primary Care Cardiovascular Society	Visual summary	002	Column 5	Semaglutide is recommended for obesity specifically here but why not tirzepatide which is more effective for weight loss. Is this due semaglutide having a licence for this? Is the comment 'only with preserved ejection fraction' valid if talking about obesity rather than heart failure per se	Thank you for your comment. The only GLP-1 receptor agonist that had evidence of clinical and cost effectiveness for people with type 2 diabetes and heart failure was subcutaneous semaglutide. The SUMMIT trial for tirzepatide includes people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not

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					fulfil the population criteria to be included in the guideline update. This means there is no evidence to show that tirzepatide is clinically or cost-effective for this population. However, people with heart failure living with obesity (the population seen in the STEP-HFpEF DM trial) would be able to access GLP-1 receptor agonists or tirzepatide through the recommendations for people living with obesity if this comorbidity is prioritised when considering therapies for further management of glycaemia if there are no reasons for them take a GLP-1 receptor agonist or tirzepatide.
Primary Care Cardiovascular Society	Visual summary	002	Column 6	Add tirzepatide now they have their CVOT data - unless has been omitted as not yet within license?	Thank you for your comment. We could not assess the SURPASS-CVOT trial, as we did not receive sufficient evidence to support assessment of the clinical effectiveness of tirzepatide. Therefore, we cannot state that tirzepatide has shown evidence of clinical effectiveness in providing cardiovascular and renal protection. Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather than tirzepatide for people with atherosclerotic cardiovascular disease at this time.
Primary Care Cardiovascular Society	Visual summary	002	Column 7	Add a comment re relaxing HbA1c targets in frailty (with examples or cross reference)	Thank you for your comment. The committee agreed that all targets should be individualised targets. Therefore, no additional wording is needed in this case.

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Primary Care Cardiovascular Society	Guideline	014	014	Many people with type 2 diabetes will have other co-morbidities. Given the range of conditions including ASCVD, heart failure, CKD and obesity it may be difficult for clinician to choose the 'best' treatment option for an individual. Can this guideline provide this? How do clinical know what column of the visual summary to follow/prioritise for an individual	Thank you for your comment and for your assessment of the clinical realities of type 2 diabetes. The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it was most important to make recommendation based on the evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. The committee agree with your assessment of multiple comorbidities. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to support this. Further information can be found in the committee discussion document.
Primary Care Cardiovascular Society	Guideline	016	014	Sick day rules for injectable GLP-1. Injectables not usually included in the sick day rules. If this is changing there needs to be clarity around the risks. What are they and how do we manage these in someone on a weekly injection. Should differentiate between (weekly) injectables and oral medication	Thank you for your comment. Regarding GLP-1 receptor agonists, we have removed this example from the recommendation. The list is also non-exhaustive, and we recommend considering the BNF and summary of product characteristics for information about the particulars of the medicine. We do not believe this should differentiate between the two as there may be some circumstances to consider

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					weekly injections as well as oral medicines. As we have not explicitly stated GLP-1 receptor agonists as an example now, we do not believe this highlights this rare scenario as more common than it is in the same way as previously.
Primary Care Cardiovascular Society	Guideline	016	015	A link to guidance regarding insulin would be useful here	Thank you for your comment. This recommendation is specific to sick day rules and the insulin-based treatments section of the guideline does not specify how to adjust insulin doses in relation to sick day rules. This will depend on the person's needs and the medicines that they are taking, and the recommendation states that this will need to be individualised to the person.
Primary Care Cardiovascular Society	Guideline	017	012	Should this also include that these medicines are also included for their effects on delaying the progression of CKD?	Thank you for your comment. We have amended this statement to include renal benefits.
Primary Care Cardiovascular Society	Guideline	018	002	Cross reference this to the advice on initiation of medicines: whether to start these medicines at the same time or sequentially and advice on expected timescale (this may also be the case for other combinations in people with co-morbidities)	Thank you for your comment. The therapy combinations for each population of interest (for example those with no comorbidities, people with heart failure, people with frailty and so on) are listed in sequential recommendations. All therapy combinations require a stepwise initiation so the recommendations for introducing medicines are listed after all population therapy information. This is to avoid repetition of the same statements and to reduce confusion.
Primary Care Cardiovascular Society	Guideline	020	012	In this section on obesity should cross reference to the obesity guidelines and where GLP-1 are recommended	Thank you for your comment. We have now added a cross reference to the guideline on overweight and obesity management. These recommendations relate to initial treatment for people with type 2 diabetes and obesity. The committee discussion highlights the committee's experience that it is possible for people to have marked improvements in

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					weight with an SGLT-2 inhibitor and metformin. Therefore, GLP-1 receptor agonists or tirzepatide should only be added at least 3 months after initial treatment with metformin and an SGLT2 inhibitor, which is covered in recommendations on treatment options if further medicines are needed.
Primary Care Cardiovascular Society	Guideline	021	016	Dapagliflozin is licensed from eGFR 15. Is the level of 20 used to be in line with NICE CKD TA for dapagliflozin (and empagliflozin)?	Thank you for your comment. Empagliflozin and dapagliflozin are recommended for people with type 2 diabetes and CKD with an eGFR of 20 ml/min/1.73 m ² and above in line with NICE's technology appraisals on Empagliflozin for treating chronic kidney disease [TA942] and Dapagliflozin for treating chronic kidney disease [TA1075] .
Primary Care Cardiovascular Society	Guideline	022	002	Remind here about dose adjustments needed for renal dosing (except linagliptin)	Thank you for your comment. The evidence reviews pooled doses for the different treatments, and therefore we do not have information around the cost effectiveness of different doses. Clinicians would be expected to consult the BNF for appropriate doses taking into account a person's comorbidities. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).

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Primary Care Cardiovascular Society	Guideline	023	012	When referring to tolerability to metformin does this mean to the initial dose or to up-titration to the maximum tolerated dose before adding in a second agent	Thank you for your comment. This means maximum tolerated dose. We have added this in for both metformin and SGLT-2 inhibitors.
Primary Care Cardiovascular Society	Guideline	025	016	When reviewing/stopping a GLP1 should also take into account heart failure and CKD in the decision as to whether to continue (noting that the glycaemic effects SGLT2i are reduced at eGFR < 45)	Thank you for your comment. The recommendation states that GLP-1 receptor agonists or tirzepatide should be stopped if they do not help the person reach their glycaemic target, except for people with type 2 diabetes and atherosclerotic cardiovascular disease or early onset type 2 diabetes where they are important for preventing cardiovascular events. This means that in people with type 2 diabetes living with obesity, if the clinician thought that the GLP-1 receptor agonist or tirzepatide was helping a person meet their glycaemic target, GLP-1 receptor agonist or tirzepatide treatment should be continued.
Primary Care Cardiovascular Society	Guideline	059	014	In relation to an increase in the number of appointments needed for adding GLP1 the assumption that future appointments for management of ASCVD, heart failure etc may be reduced is plausible however in the short term in general practice more appointments will be needed to initiate and titrate doses. Also need to make sure that there is capacity in the system for prescribing for 2DM patients and that there is a workforce available to do this within general practice – not just within specialist diabetes services	Thank you for your comments. We have adjusted the wording for this section.

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Primary Care Diabetes & Obesity Society	Guideline	General		We commend the moving of SGLT2 inhibitors and GLP-1 receptor agonists further up the decision trees; the focus on cardiovascular and renal disease, obesity, early-onset type 2 diabetes and frailty as special groups; the practicality regarding SGLT2 inhibitor safety around sick day rules, diabetic ketoacidosis and ketogenic diets. We acknowledge that there will be some challenges around implementation, especially with regard to drug availability and financial strain around GLP-1 receptor agonists, and regarding workload and capacity in primary care.	Thank you for your comment. We appreciate your feedback.
Primary Care Diabetes & Obesity Society	Guideline	General		Many concepts are not defined; e.g. "healthy living", "not meeting weight targets", "level of frailty that places them at risk of adverse events from SGLT-2 inhibitors".	Thank you for your comment. We have added clarifiers to these terms or removed these terms from the guideline if they are not appropriate. Healthy living is linked to the appropriate NHS website to provide additional information about the meaning of this. Examples of adverse events from SGLT-2 inhibitors have been provided. Weight targets have been removed from the guideline except from one example, and where targets are stated are specified as individualised targets (for HbA1c) or linked to the overweight and obesity management guideline (for weight).
Primary Care Diabetes & Obesity Society	Guideline	General		Guidance is needed on high HbA1c and retinal risk if there is sudden glucose-lowering.	Thank you for your comment. This guidance is in NICE's guideline for diabetic retinopathy. A cross reference has been added to the guideline closer to the "How to introduce medicines" section.

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Primary Care Diabetes & Obesity Society	Guideline	General		Heart failure is included within cardiovascular disease in some parts of the document yet separated out from atherosclerotic cardiovascular disease in other parts. This could be made clearer.	Thank you for your comment. We have revisited this in the document to ensure this is in line with the evidence where this has been stated. Trials were assessed as to whether they included amongst others: people with heart failure (HF) or atherosclerotic cardiovascular disease (ASCVD). Trials were only included in a group if at least 80% of the population had the characteristic. Some trials included a large population with atherosclerotic cardiovascular disease and heart failure. If trials could not be assigned to these groups, then they were included in the people at high risk of cardiovascular disease group. This meant that the group where people were at high risk of cardiovascular disease was more heterogeneous as it could include studies where some of the population could have heart failure or atherosclerotic cardiovascular disease. This made interpretation difficult and so needed to be explained in the rationale in several places.
Primary Care Diabetes & Obesity Society	Guideline	General		Repeated referral out to other NICE guidance and guidelines fragments the document.	Thank you for your comment. We appreciate the feedback and NICE is looking at improving its content. We have referred out as there is a lot of useful content in other places including content by other organisations and it is currently not practical for it to be contained in one report while making guidance that is useful and usable. We will continue to consider how we can improve on this in the future.
Primary Care Diabetes & Obesity Society	Visual summary	001-002		We commend these clear initial pathways and cohorts. However, the algorithm is very overcrowded and therefore difficult to read and use in the consultation. Some of the information which is	Thank you for your comment. The aim of the visual summary is to clearly summarise the treatment pathways as laid out in the main guideline document. NICE style generally does not use footnotes for accessibility reasons, and we believe that

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				duplicated could be placed into footnotes to make the main body of the document easier to read.	adding information into footnotes of the visual summary would make it harder for the user to locate the information.
Primary Care Diabetes & Obesity Society	Guideline	007	016	"such as increasing physical activity and losing weight" – this needs to be changed to: such as increasing physical activity with an aim to lose some of the excess body weight	Thank you for your comment. The dietary advice section of the type 2 diabetes guideline (NG28) was out of scope for this medicines update.
Primary Care Diabetes & Obesity Society	Guideline	010	013-015	"For adults on a medicine associated with hypoglycaemia, support them to aim for an HbA1c level of 53 mmol/mol (7.0%)." - HbA1c of 53 mmol/mol still has high risk of hypoglycaemia, especially patients using Sulfonylureas, who monitor their glucose with fingerprick checks. I suggest changing to – aim for HbA1c level between 53 to 58 mmol/mol (7.0 to 7.5%)	Thank you for your comment. This section was amended for updating language only and was out of scope for this guideline update. The committee agreed that these targets should be individualised. This is discussed in the recommendations after this that mention NICE's patient decision aid on type 2 diabetes: agreeing someone's blood glucose (HbA1c) target. This has been reinforced later in the guideline when discussing reviewing medicines to make this clearer. The committee does not want to set values for HbA1c as they do not have evidence to support this and do not believe this will be the best for care. Given this is a personalised goal it is up to the person with diabetes and their healthcare professional to decide whether they want to expand that range. The patient decision aid related to the guideline is available to support this.
Primary Care Diabetes & Obesity Society	Guideline	015	014-017	Is each co-morbidity considered equal? We suggest some prioritisation (e.g. if atherosclerotic cardiovascular disease is present, it supersedes obesity in terms of the pathway followed), whilst maintaining the advice on shared decision making.	Thank you for your comment and for your assessment of the clinical realities of type 2 diabetes. The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it was most important to make recommendation based on the evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. The committee agree with your

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					assessment of multiple comorbidities. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to support this. Further information can be found in the committee discussion document.
Primary Care Diabetes & Obesity Society	Guideline	016	006	Suggestion - review by clinical team if significant changes to medications during illness	Thank you for your comment. We agree that this is good practice. Medicines reviews are discussed in NICE's guideline on medicines optimisation which lists a non-exhaustive list of groups where a medication review would be appropriate. This is cross referred to in the guidance already and we do not believe we need to make another recommendation to suggest this.
Primary Care Diabetes & Obesity Society	Guideline	017	009	No mention on how to manage adults with T2D associated with hyperglycaemia symptoms	Thank you for your comment. Please see the section discussing "Hyperglycaemia" where this has been covered extensively.
Primary Care Diabetes & Obesity Society	Guideline	018	001-009	We commend the treating everyone with type 2 diabetes as high risk of atherosclerotic cardiovascular disease, as this is what QRISK	Thank you for your comment.

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				highlights, thus removing the need to consider if people are at high risk.	
Primary Care Diabetes & Obesity Society	Guideline	019	008	The guidance states that drugs are recommended at class level unless stated otherwise, but in this section, it does not specify use of an SGLT2 inhibitor with cardiovascular benefit. This could result in use of ertugliflozin, which has no evidence of cardiovascular benefit.	Thank you for your comment. We evaluated the evidence and found that ertugliflozin does have evidence of cardiovascular benefit. Therefore, we do not believe this is a necessary statement to make.
Primary Care Diabetes & Obesity Society	Guideline	020	002	It would help to define early onset diabetes here, or change the heading to "People with onset of type 2 diabetes before the age of 40 years".	Thank you for your comment. Early onset diabetes is one of the "Terms used in the guideline". This terminology is hyperlinked and people will be able to find this term in the finalised version of the guideline.
Primary Care Diabetes & Obesity Society	Guideline	020	003	What if BMI is between 25 to 29.9 kg/m ² - do we still offer GLP-1 medication as first line?	Thank you for your comment. There is no BMI threshold as the medicine is not being prescribed for weight management in this guidance. Subcutaneous semaglutide is being recommended for cardiovascular and renal protection and glycaemic benefits. Other GLP-1 receptor agonists are being considered for similar reasons and tirzepatide is being considered for glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this.
Primary Care Diabetes & Obesity Society	Guideline	020	004-005	The guidance states that drugs are recommended at class level unless stated otherwise, but in this	Thank you for your comment. We evaluated the evidence and found that ertugliflozin does have evidence of cardiovascular

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Obesity Society				section it does not specify use of an SGLT2 inhibitor or GLP-1 RA with cardiovascular benefit. This could result in use of ertugliflozin or GLP-1 RAs that have no evidence of cardiovascular benefit.	benefit. Therefore, we agreed that recommending by class would be appropriate. Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinically important reductions in cardiovascular and renal protection for other populations. However, there is no specific evidence for people with early onset type 2 diabetes and no cost effective GLP-1 receptor agonist or tirzepatide for this population. Given this, we have not recommended a specific GLP-1 receptor agonist or tirzepatide.
Primary Care Diabetes & Obesity Society	Guideline	020	012	In adults with type 2 diabetes associated with BMI >50 kg/m ² - there is strong evidence to suggest use of GLP-1 therapy in preference to SGLT-2 inhibitor	Thank you for your comment. The committee recommended initial treatment with an SGLT-2 inhibitor in addition to metformin because of the cardiovascular and renal protective benefits of SGLT-2 inhibitors. The committee discussion highlights the committee's experience that it is possible for people to have marked improvements in weight with an SGLT-2 inhibitor and metformin. Therefore, GLP-1 receptor agonists or tirzepatide should only be added at least 3 months after initial treatment with metformin and an SGLT2 inhibitor, which is covered in recommendations on treatment options if further medicines are needed. If the person's glycaemic targets have not been met, then there is a consider recommendation around using triple therapy with a GLP-1 receptor agonist or tirzepatide. If the person's weight targets have not been met, then this is outside the scope of this guideline, and users should refer to NICE's guideline on Overweight and obesity management [NG246] .
Primary Care Diabetes &	Guideline	021	016-018	This recommendation is unnecessarily narrow in listing only dapagliflozin and empagliflozin for use	Thank you for your comment. The CREDENCE trial was included in the review. The recommendations have been

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Obesity Society				down to an eGFR of 30 ml/min/1.73 m ² , excluding other SGLT2 inhibitors with similarly robust evidence in diabetic kidney disease. Notably, canagliflozin demonstrated significant renal protective effects in the CREDENCE trial (<i>N Engl J Med</i> 2019; 380 :2295-2306), including reduction in progression to end-stage kidney disease and sustained eGFR decline. Rather than specifying individual drugs, the guidance should refer to SGLT2 inhibitors with proven renal benefit from dedicated renal outcome trials in people with diabetes. This class-based framing would better reflect current evidence, support clinician flexibility, and ensure equitable access to effective therapy.	expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .
Primary Care Diabetes & Obesity Society	Guideline	022	001	DPP-4 inhibitor like Sitagliptin - medication dose needs to be tailored to the eGFR. Need to mention that in patients with eGFR below 20ml/min/1.73, Sitagliptin dose is 25mg once daily	Thank you for your comment. We appreciate your point. However, these points are discussed in the BNF and SPC. Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for prescribed medicines. These are explained in the SPC for the medicine or the British National Formulary (BNF). This applies to all medicines for NICE guidelines and so recommendations do not state this information.
Primary Care Diabetes & Obesity Society	Guideline	022	001-002	This recommendation is not evidence-based. DPP-4 inhibitors have consistently shown minimal glycaemic efficacy and offer no proven renal protection. Their continued inclusion, particularly in patients with eGFR <20 ml/min/1.73 m ² , is	Thank you for your comment. The evidence-based rationale for DPP-4 inhibitors can be read in the rationale and impact section and in detail in the committee discussion of the evidence. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost

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				unsupported by high-quality outcome data. In contrast, GLP-1 receptor agonists, especially semaglutide, have demonstrated significant renal and cardiovascular benefit, as recently confirmed in the FLOW trial (<i>N Engl J Med</i> 2024; 391 :109-121). The guidance should reflect this updated evidence and prioritise GLP-1 RAs with renal outcome data over DPP-4 inhibitors, whose use in this population lacks compelling justification.	effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Primary Care Diabetes & Obesity Society	Guideline	022	011-015	"level of frailty that places them at risk of adverse events from SGLT-2 inhibitors" requires clearer definition. In the current format, we are concerned that this will be interpreted as saying that anyone with frailty should not receive an SGLT2 inhibitor. Although metformin and then a DPP-4 inhibitor is safe, SGLT2 inhibitors also have data for safety in older people, and would be considered safer than pioglitazone or a sulfonylurea. Many frail people will also have or be at risk of cardiovascular and chronic kidney disease, and the benefits of SGLT2 inhibitors may outweigh the risks for some.	Thank you for your comment. The committee have added specific examples of the adverse events that they are concerned about. They believe that this statement is more specific than providing frailty scale grades as these are often automatically coded and can lead to incorrect assignment of people into groupings, leading to people not receiving treatments that are appropriate for them and creating health inequalities. Therefore, they believe that this is the more pragmatic method of deciding whether treatment is appropriate for someone or not.
Primary Care Diabetes & Obesity Society	Guideline	022	019-021	Recommending "the smallest number of medications at the lowest effective dosage" could imply the use of gliclazide, a potent therapy that is nonetheless unsuitable for people with frailty	Thank you for your comment. The recommendations only say to consider using a sulfonylurea if people are already taking a DPP-4 inhibitor in addition to or instead of metformin, or a DPP-4 inhibitor is contraindicated, and need further medicines

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					to manage their symptoms and reach their glycaemic targets. The guideline has a recommendation reinforcing the risks of falls and hypoglycaemia with sulfonylureas and insulin in the treatment options if medicines are needed section. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Primary Care Diabetes & Obesity Society	Guideline	025	014-015	No timeframe is suggested for stopping GLP-1 RAs if not reaching weight loss and glycaemic goals	Thank you for your comment. Wording has been added to state "individualised" next to targets. The committee agreed that arbitrary discontinuation targets should be set and that individual targets should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes. There is no specific timeframe suggested, but this should be considered when reviewing care with the person.
Primary Care Diabetes & Obesity Society	Guideline	025	016	"Stop GLP-1 receptor agonists if the person does not have atherosclerotic cardiovascular disease 16 or early onset type 2 diabetes." Why was GLP-1 medication initiated in such cases in the first instance? If treatment was initiated as	Thank you for your comment. The recommendation states that GLP-1 receptor agonists or tirzepatide should be stopped if they do not help the person reach their glycaemic target, except for people with type 2 diabetes and atherosclerotic cardiovascular disease or early onset type 2 diabetes where

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				part of obesity management, in such cases treatment needs to be continued.	they are important for preventing cardiovascular events. If a person living with obesity started treatment with a GLP-1 receptor agonist or tirzepatide, and the healthcare professional thought that the GLP-1 receptor agonist or tirzepatide was helping them meet their glycaemic targets, then GLP-1 receptor agonist treatment should be continued.
Primary Care Diabetes & Obesity Society	Guideline	027	002-008	This recommendation is too narrowly framed by focusing solely on subcutaneous semaglutide for weight management in people with diabetes and heart failure with preserved ejection fraction (HFpEF). Emerging evidence now supports the broader use of incretin-based therapies, specifically GLP-1 receptor agonists and dual GIP/GLP-1 agonists, for cardiometabolic benefit in this population. The SUMMIT and SURMOUNT HFpEF programs (including tirzepatide) are now providing robust data on dual agonists in this setting (<i>N Engl J Med</i> 2025; 392 :427-437). To reflect the evolving evidence base, the recommendation should refer to incretin-based therapies with proven cardiovascular and functional benefits in adults with diabetes and HFpEF, rather than limiting access to a single agent for weight management alone.	Thank you for your comment. The SUMMIT and SURMOUNT HFpEF trials include people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update. This means there is no evidence to show that tirzepatide is clinically or cost-effective for this population. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
Primary Care Diabetes &	Guideline	027	005-008	In this section, it is not clear if the bullet points are linked by AND or OR	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the

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Obesity Society					doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
Primary Care Diabetes & Obesity Society	Guideline	028	004	Why is only subcutaneous semaglutide recommended, given data demonstrating cardiovascular benefits of oral semaglutide (<i>N Engl J Med</i> 2025; 392 (20):2001-2012), dulaglutide (<i>Lancet</i> 2019; 394 (10193):121-130) and liraglutide (<i>N Engl J Med</i> 2016; 375 (4):311-22)? Including these agents would allow greater choice for the patient and clinician.	Thank you for your comment. McGuire 2025, Gerstein 2019 and Marso 2016 have been included in our review. The decision to recommend subcutaneous semaglutide to people with type 2 diabetes and atherosclerotic cardiovascular disease was based on cost-effectiveness evidence, as oral semaglutide, dulaglutide and liraglutide were found not to be cost effective.
Primary Care Diabetes & Obesity Society	Guideline	029	014	"further medicines are needed to reach their glycaemic targets" If patient is already using Metformin +/- SGLT-2 inhibitor, both medications have a very low risk of hypoglycaemia. In such cases adding GLP-1 therapy has significant clinical benefits. Linking this to glycaemic control can lead to delay in initiating such an important class of medication.	Thank you for your comment. GLP-1 receptor agonists apart from liraglutide were not cost effective for people living with obesity in the health economics analyses for this population. The committee have recommended that any GLP-1 receptor agonist or tirzepatide can be considered for people in this population after three months of treatment with metformin and SGLT-2 inhibitors (to ensure that the benefits from those medicines are obtained) given that all available GLP-1 receptor agonists showed glycaemic benefits and some cardiovascular benefits. The most clinically effective was subcutaneous semaglutide which was slightly over the threshold for cost-effectiveness. On the other hand, liraglutide was cost effective

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					but was less clinically effective. Other GLP-1 receptor agonists and formulations of GLP-1 receptor agonists (such as oral semaglutide) were not cost effective and were comparatively less clinically effective. Tirzepatide was shown to be cost effective in the technology appraisal for people with type 2 diabetes but did not have evidence for cardiovascular and renal benefits, which GLP-1 receptor agonists did have. This produced uncertainty in the evidence. Given this, they made a weaker consider recommendation in this case.
Primary Care Diabetes & Obesity Society	Guideline	030	013-016	Tirzepatide remaining in its current Technology Appraisal position is appropriate as no cardiovascular benefit has yet been confirmed, but in those with obesity, should it be positioned differently – alongside semaglutide – due to its superior HbA1c and weight-lowering efficacy, as demonstrated in the SURPASS clinical trial programme?	Thank you for your comment. The wording has now been changed to say “GLP-1 receptor agonist and tirzepatide” to show the role of tirzepatide in this population. Where appropriate tirzepatide has been recommended for its glycaemic benefits.
Primary Care Diabetes & Obesity Society	Guideline	031	001-009	These recommendations do not take into account results of the FLOW trial of subcutaneous semaglutide (<i>N Engl J Med</i> 2024; 391 :109-121). This feels like an opportunity to future-proof the guidance and enable optimal cardio-renal protection to a group at very high risk of reaching end-stage renal disease/cardiovascular death	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if

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					they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Primary Care Diabetes & Obesity Society	Guideline	031	019	We would not advise pioglitazone in this group, given that it increases fracture risk	Thank you for your comment. As this information on fracture risk is covered in the drug's SPC, the committee decided that it was not necessary to revisit this recommendation. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Primary Care Diabetes & Obesity Society	Guideline	052 055 059 064 065	023-024 009-010 017-018 004-005 020-021	There would be some expected increase in time required to start both metformin and an SGLT2 inhibitor in terms of counselling required; however, we agree that they can and should be prescribed as the same time, with a plan for sequential starts. In our clinical experience, an additional brief consultation is useful to confirm metformin tolerability and reinforce the commencement of the SGLT2 inhibitor. Additionally, GLP-1 receptor agonist starts are more time-consuming in terms of demonstrating injection technique. While we very much support earlier use	Thank you for your comment. We have adjusted the wording to reflect this.

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				to reduce cardiovascular events, we acknowledge this will somewhat increase workload in primary care in the earlier stages of disease.	
Primary Care Diabetes & Obesity Society	Guideline	055	027-028	We commend this section and would add that underprescribing of SGLT2 inhibitors also occurs in women, older people and Black people	Thank you for your comments and support of this section. Lower levels of SGLT-2 inhibitor prescribing in women, older people and Black or Black British people is described in the epidemiological SGLT-2 inhibitor Uptake Report as part of the documents listed in the draft guidance consultation.
Public Health Collaboration	Guideline	General		The updates to the individualised care (1.1) and dietary advice sections (1.3) do not address concerns that we had previously expressed in conjunction with the British Dietetic Association (BDA) and X-PERT Health. These concerns were set out in an open letter that can be accessed at https://www.xperthealth.org.uk/wp-content/uploads/2025/03/Letter-to-NICE-re-NG28-FINAL.pdf. The response to this letter (on behalf of NICE) intimated that amendments would be made as part of the current update to address these concerns. However, the updated guidance still fails to: 1. make it clear that remission of type 2 diabetes is a realistic goal for many 2. support a range of dietary approaches	Thank you for your comment. The visual summary has a box at the start of the document that says to reinforce advice about diet and healthy living at each point in the pathway. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. This draft guideline consultation was to update the Type 2 Diabetes guideline for medicines. Therefore, the dietary advice section of the type 2 diabetes guideline medicines update (NG28) was out of scope. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes

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				3. support shared decision making through the promotion of individualised and flexible approaches, which would help patients to adopt a way of eating that meets their needs and preferences. This means the dietary advice in NG28 does not reflect other national and international guidelines for adults living with type 2 diabetes or its own advice for adults with overweight or obesity NG246. These inconsistencies risk confusion amongst healthcare professionals and the public. The required changes could be easily incorporated by 1) Substituting the outdated guidelines in NG28 with sections 1.16.1 and 1.16.3 from NG246 to promote flexible and individualised dietary approaches. 2) Adding a statement about type 2 diabetes remission through dietary approaches as a treatment target. We feel these changes are justified without the need for further evidence reviews as the evidence review for NG246 included studies with people with	guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A cross reference has been added to recommendations on low-energy and very-low-energy diets for the management of type 2 diabetes which was considered as part of the update of the overweight and obesity management guideline (NG 246). Regarding the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes. This review included interventions with a minimum of 3 months duration. This review considered short term interventions and the evidence suggested beneficial effects on HbA1c, fasting plasma glucose and serum triacylglycerol in the shorter term (up to 6 months). However, no differences were observed in the longer term (over and including 12 months). The role of low carbohydrate diets was considered in the updated overweight and obesity management guideline (NG246). The guideline committee were keen that the review examined the long-term effectiveness of different diets (including low carbohydrate diets). Therefore, the review

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				type 2 diabetes. Also, that the recommendations of the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes support these amendments.	protocol outlined that interventions with a minimum follow-up of 12 months should be included. The review included four RCTs looking at low carbohydrate diets in people with type 2 diabetes and four RCTs looking at very low carbohydrate diets in people with type 2 diabetes. The findings showed that it could not differentiate between the interventions (low carbohydrate or very low carbohydrate diets vs usual care/ support) in key outcomes such as weight at one year, % change in HbA1c, waist circumference and Quality of Life. In terms of shared decision making, we agree that this is an important part of care. The dietary advice section of the guideline recommends providing individualised and ongoing nutritional advice. The guideline also cross-references to NICE's guideline on shared decision making, which covers how to make shared decision-making part of everyday care in all healthcare settings and promotes ways for healthcare professionals and people using services to work together to make decisions about treatment and care. Based on the evidence and their expertise, the committee amended an existing recommendation stating that dietary approaches to support weight loss should maintain an energy deficit and this can be achieved by lowering specific macronutrient content (recommendation 1.16.3 in NG246).

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Public Health Collaboration	Visual summary	001	Box 1	The sentence “At each point reinforce advice about diet and behaviour change.” Should be replaced with a call to action on remission of type 2 diabetes as a realistic target. Introducing the benefits of remission before starting medication is a golden opportunity to give hope and agency to the individual. It should include a discussion of the options – low calories soups and shakes, low carbohydrate diet and intermittent fasting and the goals and existing experience of the patient. It should also incorporate support and monitoring such as through regular blood tests, waist circumference and weight measurements as these are significant motivators for achieving and sustaining remission. Including the fact that 50% remission rate is achievable and that remission is more likely the earlier it is attempted would emphasise the importance of having these conversations early in the process..	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. We have added a recommendation in the ‘Involving people in medicine discussions’ section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
Public Health Collaboration	Guideline	005	004	Rec 1.1.4 We are concerned that the contradictory dietary advice between NG28 and NG246 will add to the confusion amongst health care practitioners and the public over how to manage type 2 diabetes using diet. NG246 promotes flexible and individualised dietary approaches, and a range of different eating patterns. NG28 does not. It	Thank you for your comment. This draft guideline consultation was to update the Type 2 Diabetes guideline for medicines. Therefore, the dietary advice section of the type 2 diabetes guideline (NG28) was out of scope. However, we have added a recommendation in the ‘Involving people in medicine discussions’ section that highlights the need to discuss healthy living advice when considering medicines and continuing the

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				promotes a medicalised approach to a lifestyle disease. This is especially concerning as remission is not possible through this route. The required changes could be easily incorporated by 1) Substituting the outdated guidelines in NG28 with sections 1.16.1 and 1.16.3 from NG246 to promote flexible and individualised dietary approaches. 2) Adding a statement about type 2 diabetes remission through dietary approaches as a treatment target. We feel these changes are justified without the need for further evidence reviews as the evidence review for NG246 included studies with people with type 2 diabetes. Also, that the recommendations of the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes support these amendments.	personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. Acknowledgement in the guideline is made to low-energy and very-low-energy diets for the management of type 2 diabetes which was considered as part of the update of the overweight and obesity management guideline (NG 246). Regarding the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes. This review included interventions with a minimum of 3 months duration. This review considered short term interventions and the evidence suggested beneficial effects on HbA1c, fasting plasma glucose and serum triacylglycerol in the shorter term (up to 6 months). However, no differences were observed in the longer term (≥ 12 months). The role of low carbohydrate diets was considered in the updated overweight and obesity management guideline (NG246). The guideline committee were keen that the review examined the long-term effectiveness of different diets (including low carbohydrate diets). Therefore, the review protocol outlined that interventions with a minimum follow-up of 12 months should be included.

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					The review included four RCTs looking at low carbohydrate diets in people with type 2 diabetes and four RCTs looking at very low carbohydrate diets in people with type 2 diabetes. The findings showed that it could not differentiate between the interventions (low carbohydrate or very low carbohydrate diets vs usual care/ support) in key outcomes such as weight at one year, % change in HbA1c, waist circumference and Quality of Life. Based on the evidence and their expertise, the committee amended an existing recommendation stating that dietary approaches to support weight loss should maintain an energy deficit and this can be achieved by lowering specific macronutrient content (recommendation 1.16.3 in NG246).
Public Health Collaboration	Guideline	007	011	Rec 1.3.4 We believe that reference to the Pathway to Remission Programme would be better included in the context of remission being a realistic target for adults with type 2 diabetes and that there are a range of dietary approaches (including the pathway to remission programme) through which remission can be achieved. That the decision of which approach to take is personal and that support is a key contributor to success. The low carbohydrate approach and intermittent fasting should be included for completeness.	Thank you for your comment. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. Regarding including a low carbohydrate approach and intermittent fasting for completeness. The role of low carbohydrate diets was considered in the updated overweight and obesity management guideline (NG246). The guideline

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					committee were keen that the review examined the long-term effectiveness of different diets (including low carbohydrate diets). Therefore, the review protocol outlined that interventions with a minimum follow-up of 12 months should be included. The review included four RCTs looking at low carbohydrate diets in people with type 2 diabetes and four RCTs looking at very low carbohydrate diets in people with type 2 diabetes. The findings showed that it could not differentiate between the interventions (low carbohydrate or very low carbohydrate diets vs usual care/ support) in key outcomes such as weight at one year, % change in HbA1c, waist circumference and Quality of Life. Based on the evidence and their expertise, the committee amended an existing recommendation stating that dietary approaches to support weight loss should maintain an energy deficit and this can be achieved by lowering specific macronutrient content (recommendation 1.16.3 in NG246). The effectiveness of intermittent fasting approaches was also considered in the updated overweight and obesity management guideline (NG246). Some evidence was identified on intermittent energy-restriction approaches such as alternate-day fasting and time-restricted eating. This showed improvement for a few outcomes, but for

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					most outcomes it was not effective. The committee also noted the variation in approaches to intermittent energy restriction and that there were problems with the studies, such as not being able to differentiate between the intervention and control for some outcomes. This guideline committee did not make recommendations on these diets but made a recommendation for research on intermittent fasting in adults to encourage better quality trials.
Public Health Collaboration	Guideline	008	009	Rec 1.3.11 We are concerned that the contradictory dietary advice between NG28 and NG246 will add to the confusion amongst health care practitioners and the public over how to manage type 2 diabetes using diet. NG246 promotes flexible and individualised dietary approaches, and a range of different eating patterns. NG28 does not. It promotes a medicalised approach to a lifestyle disease. This is especially concerning as remission is not possible with this route. The required changes could be easily incorporated by 1) Substituting the outdated guidelines in NG28 with sections 1.16.1 and 1.16.3 from NG246 to promote flexible and individualised dietary approaches.	Thank you for your comment. This draft guideline consultation was to update the Type 2 Diabetes guideline for medicines. Therefore, the dietary advice section of the type 2 diabetes guideline medicines update (NG28) was out of scope. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A cross reference has been added to recommendations on low-energy and very-low-energy diets for the management of type 2 diabetes which was considered as part of the update of the overweight and obesity management guideline (NG 246). Regarding the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes. This review included

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				2) Adding a statement about type 2 diabetes remission through dietary approaches as a treatment target. We feel these changes are justified without the need for further evidence reviews as the evidence review for NG246 included studies with people with type 2 diabetes. Also, that the recommendations of the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes support these amendments.	interventions with a minimum of 3 months duration. This review considered short term interventions and the evidence suggested beneficial effects on HbA1c, fasting plasma glucose and serum triacylglycerol in the shorter term (up to 6 months). However, no differences were observed in the longer term ($\geq$ 12 months). The role of low carbohydrate diets was considered in the updated overweight and obesity management guideline (NG246). The guideline committee were keen that the review examined the long-term effectiveness of different diets (including low carbohydrate diets). Therefore, the review protocol outlined that interventions with a minimum follow-up of 12 months should be included. The review included four RCTs looking at low carbohydrate diets in people with type 2 diabetes and four RCTs looking at very low carbohydrate diets in people with type 2 diabetes. The findings showed that it could not differentiate between the interventions (low carbohydrate or very low carbohydrate diets vs usual care/ support) in key outcomes such as weight at one year, % change in HbA1c, waist circumference and Quality of Life. Based on the evidence and their expertise, the committee amended an existing recommendation stating that dietary approaches to support weight loss should maintain an energy

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					deficit and this can be achieved by lowering specific macronutrient content (recommendation 1.16.3 in NG246).
Renal Pharmacy Group	Guideline	019	004-009	Current guidance states a clear BMI threshold for starting GLP1 analogues. Is the recommendation to start SC semaglutide in patients with atherosclerotic disease irrespective of current BMI? It would be helpful if this could be clarified and made clear on guidance to support clinical decision making in practice.	Thank you for your comment., There is no BMI threshold for starting GLP-1 receptor agonists in this group. Subcutaneous semaglutide is being recommended for cardiovascular and renal protection as well as glycaemic benefits. This wording has been added to the recommendation.
Renal Pharmacy Group	Guideline	019	009	In patients with atherosclerotic cardiovascular disease the recommendation is for SC semaglutide. Many patients will already be prescribed tirzepatide which may be the preferred choice for greater HbA1c reduction/weight loss. Will the emerging evidence from SURPASS CVOT be considered and reflected in the guidance?	Thank you for your comment. Not enough evidence was received for the SURPASS-CVOT trial to assess cardiovascular and renal benefits for tirzepatide in people with atherosclerotic cardiovascular disease. Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide for people with atherosclerotic cardiovascular disease at this time. Any relevant studies published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline
Renal Pharmacy Group	Guideline	020	003-005	It would be helpful if there is a recommended BMI threshold for starting GLP1 analogues in this population	Thank you for your comment. There is no BMI threshold as the medicine is not being prescribed for weight management in this guidance. Subcutaneous semaglutide is being recommended for cardiovascular and renal protection and glycaemic benefits.

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					Other GLP-1 receptor agonists are being considered for similar reasons and tirzepatide is being considered for glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology appraisals. Edits have been made to the guideline to reinforce this.
Renal Pharmacy Group	Guideline	021	008-018	The FLOW trial (Semaglutide in patients with T2D and CKD) demonstrated 24% RRR in primary outcome (major kidney disease events, at least 50% reduction in eGFR from baseline or death from kidney related or CV causes). It would be helpful to consider this earlier in the pathway for this patient group (prior to DPP4/pioglitazone/insulin) given the significant CV benefits and degree of CV risk in patients with T2D and CKD.	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Renal Pharmacy Group	Guideline	027	002-008	Point 1.8.47: Suggests SC Semaglutide based of evidence from STEP-HFpEF trial. Will evidence from SUMMIT trial (lower risk of composite death from CV causes or worsening heart failure) be	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited

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				considered to recommend use of tirzepatide? This will be a preferred option for some patients given greater HbA1c and weight reductions	evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management. The SUMMIT trial includes people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update. This means there is no evidence to show that tirzepatide is clinically or cost-effective for this population.
Renal Pharmacy Group	Guideline	031	001-009	GLP1 analogues not recognised anywhere in the pathway for patients with T2D and CKD despite evidence of risk reduction in primary kidney and CV endpoints with semaglutide in FLOW trial and trials in progress (TREASURE-CKD). Recognising high cardiovascular risk of patients with T2D and CKD this should be reflected in guideline suggestions	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets

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					(as per guidance about choosing which comorbidity to manage). Any potentially relevant studies such as the TREASURE-CKD trial published after the publication of this guideline will be picked up by the NICE surveillance team and will be considered for inclusion in future updates of the guideline
Royal College of General Practitioners	Guideline	General		We believe, this guideline represents a significant update, with stronger recommendations on the use of SGLT-2 inhibitors and GLP-1 receptor agonists based on cardiometabolic benefits.	Thank you for your comment. We appreciate the feedback.
Royal College of General Practitioners	Guideline	General		We recommend that the guidance includes specific measures and sections to address key populations at risk of health inequalities who have type 2 diabetes i.e. for people living with a severe mental illness (SMI) as well as people living with a Learning Disability: We recommend recognising the importance of understanding issues such as obesity and the metabolic risks linked to antipsychotic use. We would like to highlight existing resources like the STOMP programme. It is important that educational materials are created in accessible formats. The effect of learning disabilities and mental illness on the understanding of the condition with opportunities for self-management of this long-term condition. We recognise that this form of shared	Thank you for your comment. Following the change in the recommendation of immediate release metformin to modified release metformin for most, an additional recommendation has been made for people with a learning disability. We have not made specific recommendations for people with a severe mental illness or further recommendations for people with a learning disability in most cases as the committee agreed that the main principles of medicine treatment are the same. However, treatment may need to account for the effects of other medicines, supporting self-management and making reasonable adjustments to help people access care. Guidance about the latter can be found in NICE's guidance on patient experience in the NHS which has been cross-referred to in this guideline. Taking into account that each of these will be on a case by case basis, the committee agreed that further recommendations would not be made in this scenario.

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				decision making creates a more personalised approach.	Patient experience and specific adjustments that are needed for individual patients underpin all NICE recommendations and so it is a given that healthcare professionals use their judgment and discussion with service users together with the guidelines to make appropriate adjustments for those with mental health illness or other conditions and issues.
Royal College of General Practitioners	Guideline	General		We recommend that the following principles are embedded throughout commissioning plans, clinical pathways, and service development: • People with a learning disability die on average 20 years earlier than the general population, often due to poorer access and management of healthcare (NHS England » Learning disability and autism programme update). • Guidance should reference the NHS England Mental Capacity Act implementation guidance. • Reasonable adjustments should be a standard requirement in all commissioning and service development plans.	Thank you for your comment. We agree that this is a really important area and NICE is committed to improving the care and experience for people with a learning disability. The guideline cross refers to NICE's guideline on patient experience in the NHS that considers these factors. This guidance applies to all NICE recommendations and so is not reiterated in every guideline.

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				- We draw attention to: Reasonable Adjustment Campaign Reasonable Adjustment Flag – NHS England Digital. - We recommend explicit guidance for clinicians on avoiding diagnostic overshadowing, where symptoms of physical or mental illness are wrongly attributed to a person's learning disability or autism. - Reference: NHS England » Clinical guide for front line staff to support the management of patients with a learning disability and autistic people. - Easy read resources should be standard, with capacity for translation or adaptation. See: NHS England » Patient safety healthcare inequalities reduction framework.	

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				- Hidden but relevant conditions (e.g., constipation) should be recognised as common in people with a learning disability (NICE CKS: Associated conditions). - We note the lack of research specifically including people with a learning disability. This should not lead to under-prioritisation of their needs. - We recommend structured liaison with families, carers, community LD nurses, and secondary care LD teams to ensure continuity of care. We recommend that professional curiosity about the possibility of a learning disability should be a standard expectation within any diabetes care guidance.	
Royal College of General Practitioners	Visual summary	General		The overlap between comorbidity pathways (CVD, CKD, obesity) may be confusing for non-specialists. We recommend a clearer prioritisation guidance which would be helpful.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. The evidence analysed in this review has been presented for each discrete comorbidity. Given this, the committee decided it was most important to make recommendation based on the

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					evidence they had available to them and provide this clearly, then allow flexibility in how treatments are used outside of this when people have multiple conditions. However the committee agree with your assessment of multiple comorbidities. A recommendation was added with simplified principles for managing care when people have multiple comorbidities including; 1. Additional therapies can be offered to reduce the risk of cardiovascular and renal disease (if indicated for one comorbidity but not another) 2. If there are safety concerns because of a comorbidity, then a treatment should not be considered 3. Polypharmacy should be considered with options to reduce number of medicines and doses to minimise adverse events We have added wording to advise people to account for: a) medicines required for cardiovascular and renal protection, b) medicines that are contraindicated, c) medicines optimisation especially for people with frailty. Further information can be found in the committee discussion document.
Royal College of General Practitioners	Guideline	012-014	020	Recommendations on CGM access are positive, but we believe they should include explicit guidance on supporting primary care teams in interpreting CGM data, as most provision and follow-up is in general practice.	Thank you for your comment. This section is out of scope for the guideline update.

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				Additionally, earlier intensification of glucose-lowering therapy may require additional monitoring, staff training, and patient education, which could be difficult for practices with limited diabetes specialist nurses. Access to structured education programmes and continuous glucose monitoring (CGM) is also variable across regions, potentially creating inequity. We believe implementation could be supported by referencing existing NHS Diabetes Transformation Programmes, digital self-management platforms, and national workforce training initiatives.	
Royal College of General Practitioners	Guideline	018	013	We believe that recommending metformin plus SGLT-2 inhibitor as first-line therapy represents a major shift. This raises questions about: ○ Patient acceptability: starting dual therapy immediately after diagnosis may feel burdensome. Affordability and local prescribing (primary care budgets are already under strain).	Thank you for your comment and your focus on what matters to patients. We agree that this is an area of concern and acknowledged this in the committee discussion document. However, we believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes and that people with diabetes can choose this based on the information provided in consultations. We acknowledge that this does bring a larger treatment burden to it. However, there is an initial staggered start to treatment (starting modified release metformin, ensuring that the maximum tolerated dose is reached before starting SGLT-2 inhibitors) which may help to gradually start treatment. The timings for starting this can be adjusted as a reasonable adjustment if this is overwhelming the person to help them to adapt to starting treatment. The committee also

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					agreed that people with type 2 diabetes should be counselled to ensure that these concerns are discussed and to support them to start treatment.
Royal College of General Practitioners	Guideline	019	015	We are concerned that the inclusion of subcutaneous semaglutide alongside SGLT-2 inhibitors for people with ASCVD has practical issues for primary care: ○ Limited primary care experience initiating GLP-1 therapy (usually specialist-led) ○ Patient acceptability: starting triple therapy immediately after diagnosis may feel very burdensome ○ Costs and formulary approval	Thank you for your comment. We appreciate these concerns. We believe that these recommendations are still important for reducing the development of cardiovascular disease and leading to death and long-term negative outcomes for people with type 2 diabetes. Starting these medicines early is critical for this. In doing this it will ultimately lower the cost impact as less people will need to access services for care for subsequent cardiovascular disease. However, as with all NICE guidelines, the recommendations should be discussed with the person affected so as to come to a shared decision between the person and the healthcare worker regarding their treatment pathway that is right for them and is ultimately their choice. Regarding limited experience, we have received a mixture of reports about this. The committee agreed that there was no safety reason why GP practices should not be able to support initiation of therapy by working as a multidisciplinary team with GPs and practice nurses with support from secondary care as required. If services for initiating therapy are not available within the GP practice, then support should be sought from secondary care. The cost effectiveness and resource impact has been considered in the guideline and materials (including the

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					resource impact calculator) is provided alongside the guidance to support implementation.
Royal College of General Practitioners	Guideline	022	010	We would like to highlight that the recognition that frail patients are at higher risk of adverse effects from SGLT-2 inhibitors is important. We believe, the guidance to minimise polypharmacy is sensible. However, it is important to note that frailty assessment is variably embedded in routine GP and requires time and resources.	Thank you for your comment and support. We acknowledge this and appreciate the challenge in this. We hope that by providing a pragmatic method of deciding this that it will support this.
Royal College of Nursing	Visual Summary			Whilst this visual summary is much called for, again mention of GLP-1/GIPs has not been considered and should be taken into account to support patients and nursing staff in terms of use of this medication	Thank you for your comment. The term in the guideline has changed to "GLP-1 receptor agonist or tirzepatide" to capture the place for tirzepatide in the guideline.
Royal College of Nursing	Guideline	006	011	1.2.4 – This criterion is sensible but no recommendation of whether an online option would be suitable, may want to consider for those who would prefer considering a four-country approach of what is available	Thank you for your comment. This is out of scope for the guideline update.
Royal College of Nursing	Guideline	007	007	1.3.3 – The recommendation for encouraging healthy diet is crucial, however it is not mentioned regarding fruit intake in terms of the impact this may have on glycaemic control if consumed in excessive amounts, may want to consider the need to tailor to individual needs	Thank you for your comment. This is out of scope for the guideline update. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the

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Stakeholder	Document	Page No	Line No	Comments	Developer's response
					NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.
Royal College of Nursing	Guideline	011	006	1.7.9 – We are concerned to see that frailty has not been mentioned explicitly here, this would be crucial to add to help clinicians recognise the importance of frailty linked to HbA1c targets – use of Strain et al. (2021) model may help support this - Diabetes and Frailty: An Expert Consensus Statement on the Management of Older Adults with Type 2 Diabetes - PMC (however later on in the guidance a small mention is made for point 1.8.8, therefore needs to be built on)	Thank you for your comment. This section is out of scope for the guideline update.
Royal College of Nursing	Guideline	012	008	1.7.15 – consideration here needs to be highlighted around ketosis prone diabetes and need for monitoring	Thank you for your comment. This section is out of scope for the guideline update.
Royal College of Nursing	Guideline	013	013	1.7.20 - We agree with the need for those trained in CGM to be able to apply this, however the word 'expert' can be misleading and may impact in practice on clinicians thinking they are not suitable to initiate/support when they have been trained if do not deem themselves an expert in this, may want to consider rephrasing	Thank you for your comment. This section is out of scope for the guideline update.
Royal College of Nursing	Guideline	013	018	1.7.21 – We appreciate the need for accuracy checks re CGM vs finger pricks, but limited guidance is here to suggest what this accuracy may look like impacting on how clinicians feel in practice around this concept	Thank you for your comment. This section is out of scope for the guideline update.

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Royal College of Nursing	Guideline	014	013	1.7.26 – The need to identify groups is crucial, however it may also be worth considering identifying areas of practice i.e. primary care that may need support or help with identifying those eligible but have lower uptake	Thank you for your comment. This section is out of scope for the guideline update.
Royal College of Nursing	Guideline	015	020	1.8.23 – We are wanting to highlight that a reference to FSRH guidance could also be made here regarding contraception and use of GLP-1 therapies to support practice	Thank you for your comment. The guidance from the College of Sexual & Reproductive Healthcare (previously known as the FSRH) is referenced in the MHRA warning and so we do not believe we need to add a second reference in about this.
Royal College of Nursing	Guideline	018	007	1.8.10 – We recommend also addition of if someone is suffering from side effects to consider use of modified-release preparations	Thank you for your comment. Following committee discussion, the committee agreed that modified release metformin would have better tolerance and subsequent adherence than standard-release metformin. Therefore, we have updated the recommendations to recommend modified-release metformin as first line for all people prescribed metformin.
Royal College of Nursing	Guideline	020	005	1.8.18 – We are wanting to clarify what you mean by the term 'consider' in this guidance, as this can open to interpretation and need clear guidance on use to support practice	Thank you for your comment. The term 'consider' in all NICE guidelines means that the recommendation is not based on strong evidence. In this recommendation, it is as the clinical evidence is indirect (derived from evidence for people at high risk of developing atherosclerotic cardiovascular disease, who were more often an older population), and the cost-effectiveness analysis showed that it was not cost-effective. However, the committee agreed that the recommendation was important noting the limitations in the evidence base, the population-specific risk factors and health inequalities data. Therefore, the healthcare professional involved in the decision making process should consider whether this is appropriate for

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					the person they are supporting with care before initiating the therapy along with the person's preferences and the limitations in the evidence. Consider recommendations will likely help people but may not be appropriate for all people. In comparison, offer recommendations are very likely to help people and instead there may be exceptional circumstances where it is unlikely to be helpful. In all cases, healthcare professionals should use their judgement to decide if this is appropriate for the person they are supporting.
Royal College of Nursing	Guideline	020	015	1.8.21 – We are concerned to see that no mention of GLP-1 receptor agonists or GLP-1/GIPs have been mentioned within this section, considering the extreme benefit these add to those living with diabetes and obesity, also no parameters have been listed around BMI and use	Thank you for your comment. The committee recommended initial treatment with an SGLT-2 inhibitor in addition to metformin because of the cardiovascular and renal protective benefits of SGLT-2 inhibitors. The committee discussion highlights the committee's experience that it is possible for people to have marked improvements in weight with an SGLT-2 inhibitor and metformin. Therefore, GLP-1 receptor agonists or tirzepatide should only be added at least 3 months after initial treatment with metformin and an SGLT2 inhibitor, which is covered in recommendations on treatment options if further medicines are needed. If the person's glycaemic targets have not been met, then there is a consider recommendation around using triple therapy with a GLP-1 receptor agonist or tirzepatide. If the person's weight targets have not been met, then this is outside the scope of this guideline, and users should refer to NICE's guideline on Overweight and obesity management [NG246].

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Royal College of Nursing	Guideline	020	016	1.8.26 – Whilst recommendations for CKD is called for, consideration of specialist renal input should be noted to help clinicians regarding management and ensuring appropriate review for the patient alongside use of medications	Thank you for your comment. The recommendations on initial medicines in people with type 2 diabetes and chronic kidney disease reference NICE's guideline on chronic kidney disease [NG203] , which covers management and review of people with CKD.
Royal College of Nursing	Guideline	022	011	1.8.30 – Again, whilst frailty has been mentioned, we are concerned to see no specific parameters have been mentioned regarding the level of frailty that may pose an individual at risk, opening this to interpretation and possibly impacting on who may or may not receive treatment	Thank you for your comment. The committee have added specific examples of the adverse events that they are concerned about. They believe that this statement is more specific than providing frailty scale grades as these are often automatically coded and can lead to incorrect assignment of people into groupings, leading to people not receiving treatments that are appropriate for them and creating health inequalities. Therefore, they believe that this is the more pragmatic method of deciding whether treatment is appropriate for someone or not.
Royal College of Nursing	Guideline	025	016	1.8.43 – Clarification may be required here as clinicians will need to understand if this means people who are already on a GLP-1 (or GLP-1/GIP as not mentioned) with established control, would this mean stopping the preparation? Further guidance would support clinician decision making	Thank you for your comment. This section discusses "Reviewing other medicines". Therefore, it is assumed that this is discussing people already taking a GLP-1 receptor agonist or tirzepatide. It would not be achieving control if it is not helping the person to reach their individualised glycaemic targets, so adding this would not help to provide clarity. Therefore, we have not added wording around this. Healthcare professionals can choose to try different preparations where appropriate for the indication, which is not prohibited by the recommendation wording.
Royal College of Nursing	Guideline	026	002	1.8.49 – New guidance now available regarding the cardiovascular outcomes for GLP-1/GIPs thus this needs to be taken into consideration for use in	Thank you for your comment. While we have seen these findings, we have not seen a full manuscript detailing the methods and results in a manner we can include in the review.

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				practice as only mentioned in a very small part later on in the guidance - Lilly's Mounjaro (tirzepatide), a GIP/GLP-1 dual agonist, demonstrated cardiovascular protection in landmark head-to-head trial, reinforcing its benefit in patients with type 2 diabetes and heart disease Eli Lilly and Company	Therefore, we cannot confirm that tirzepatide shows cardiovascular protection for people with type 2 diabetes with atherosclerotic cardiovascular disease. Given this, it has not been recommended for this group.
Royal College of Nursing	Guideline	028	012	1.8.51 – Again concerned no mention of GLP-1/GIPs within this section as readily available in practice for those who meet local criteria and have increased improvements in weight loss/glycaemic control compared to semaglutide - Tirzepatide as Compared with Semaglutide for the Treatment of Obesity New England Journal of Medicine (SURPASS Trial)	Thank you for your comment. The SURPASS trial includes people with obesity but not necessarily with type 2 diabetes. Therefore, it is not applicable to the protocol and was excluded from the guideline review. We have now amended the wording in the recommendation to say “GLP-1 receptor agonist and tirzepatide” to reflect the role of tirzepatide in management of type 2 diabetes for this population.
Royal College of Nursing	Guideline	030	010	1.8.56 – We are concerned to see Pioglitazone being recommended considering the effects on weight gain for those living with diabetes and obesity	Thank you for your comment. Here pioglitazone is being recommended as an option in situations where adults with T2DM need further medication to reach their glycaemic targets where GLP-1 receptor agonists are contraindicated, not tolerated, not appropriate or not effective. As information on weight gain monitoring is covered in the drug's SPC, the committee decided that it was not necessary to revisit this recommendation. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around

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					making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC).
Royal College of Nursing	Guideline	031	001	1.8.56 – We are concerned to see no mention of the FLOW trial in consideration of CKD and diabetes for use of semaglutide, may need to consider in revision: Effects of Semaglutide on Chronic Kidney Disease in Patients with Type 2 Diabetes New England Journal of Medicine	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
Royal College of Nursing	Guideline	032	005	1.8.61 – This recommendation may be challenging in practice where this structured education is not available, may need to consider how initiated in primary care	Thank you for your comment. We appreciate your concern and this makes practical sense. However, we believe this is important and so prioritising providing a structured education programme (whether delivered by someone in the practice or by an external service) is important if the practice wants to start someone on insulin. This recommendation has been in place since 2015 with only minor amendments to the wording to reinforce the meaning in this update of the guideline.

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Royal College of Nursing	Guideline	042	002	3 – again no mention of GLP-1/GIP within this section and may need to be considered as is being used within clinical practice	Thank you for your comment. We have changed the wording to “GLP-1 receptor agonist or tirzepatide” and included tirzepatide in the research recommendation.
Royal College of Nursing	Guideline	048	021	Sick day rules – very important to consider and need to think about what education is given on initiation of medications and how this is documented in practice	Thank you for your comment.
Royal College of Ophthalmologists	Guideline	009	001	Section 1.7 Blood glucose management The new section in NG28 would ideally state something along the lines of: • If starting a GLP-1 receptor agonist or insulin in Type 2 diabetes where there is a risk of rapid reduction in HbA1c there is a potential risk of rapid worsening of diabetic eye disease (early worsening phenomenon). • For patients whose diabetic eye disease is being monitored via the NHS Diabetic Eye Screening Programme with no retinopathy (R0M0) or background diabetic retinopathy (R1M0), the clinician managing the systemic diabetes should ensure that the patient attended their most recent diabetic eye screening assessment and that the patient is remaining under the care of the screening programme and has not been	Thank you for your comment and for raising this issue. This was considered by the committee and a cross reference to the diabetic retinopathy: management and monitoring guideline (NG242) was added in the how to introduce medicines section. This guideline has a recommendation advising when starting a diabetes treatment that is likely to result in a rapid, substantial drop in the person's HbA1c, notify the person's ophthalmologist so they can assess the person's eyes before treatment begins and check for changes afterwards. The retinopathy risk with semaglutide and other GLP-1 receptor agonists recommended in the guideline is included in the BNF. The expectation is that all prescribers would be aware of the guidance in the BNF for the products that they are prescribing. This issue has also been discussed in the rationale and impact section of this guideline update.

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				referred to the Ophthalmology service for further assessment or treatment prior to commencement of systemic diabetes medication likely to cause a rapid reduction in HbA1c. It is recommended that the clinician responsible for the patient's systemic diabetes control communicates with the Ophthalmology team caring for patients under the care of Ophthalmology for diabetic eye disease to confirm if it would be safe to commence additional diabetes medications immediately or if the diabetic eye disease needs additional treatment to stabilise the diabetic eye disease prior to commencement of new systemic diabetes medication.	
Royal College of Ophthalmologists	Guideline	014	017-020	It might be helpful to put a section in re caution in starting GLP-1 receptor agonists or insulin in Type 2 diabetics due to the risk of early worsening phenomenon if there is more advanced diabetic eye disease and there is an anticipated large sudden reduction in HbA1c over a short time period. This is referred to in NICE guidance on diabetic retinopathy NG242 https://www.nice.org.uk/guidance/ng242	Thank you for your comment. We agree that this is an important risk when there is a large sudden reduction in HbA1c over a short period of time. This has been emphasised in NICE's guideline on diabetic retinopathy, as you have mentioned. We have added more cross references to this into the guideline to ensure this is at the forefront of prescriber's minds.

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Royal College of Ophthalmologists	Guideline	038	027	1.9.20 When adults are diagnosed with type 2 diabetes, refer them immediately to the local eye screening service. [2009, amended 2020] They will automatically be referred for screening via GP2DRS therefore this is now not needed unless there is a change in policy)	Thank you for your comment. We have kept this recommendation as it is for now to ensure that a referral is made to the local eye screening service (even if it is made through an automatic system).
Royal College of Ophthalmologists	Guideline	039	010-012	1.9.23 Refer to an ophthalmologist in accordance with the UK National Screening Committee criteria and timelines for any large sudden unexplained drop in visual acuity. [2009, amended 2020] this should now be NHS DES screening guidance.	Thank you for your comment. We have amended this recommendation to discuss and link to the NHS Diabetic eye screening pathway standards.
Royal College of Psychiatrists	Guideline	General		The guideline document, however, makes no mention of severe mental illness, only mentions learning disability in the context of continuous glucose monitoring and only mentions dementia in the context of	Thank you for your comment. Following the change in the recommendation of immediate release metformin to modified release metformin for most, additional acknowledgement has been made for people with a learning disability in the rationale. We have not made any further recommendations for people with learning disabilities or for people with a severe mental illness as the committee agreed that the main principles of medicine treatment are the same. However, treatment may need to account for the effects of other medicines, supporting self-management and making reasonable adjustments to help people access care. Guidance about the latter can be found in

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					NICE's guidance on patient experience in the NHS which has been cross-referred to in this guideline. Patient experience and specific adjustments that are needed for individual patients underpin all NICE recommendations and so it is a given that healthcare professionals use their judgment and discussion with service users together with the guidelines to make appropriate adjustments for those with mental health illness or other conditions and issues.
Royal College of Psychiatrists	Guideline	General		Patients (usually, but not exclusively, with severe mental illness) taking certain antipsychotics, clozapine and olanzapine in particular, may experience particular challenges around glycaemic control and may require a different approach to medication for T2DM. It would be important at the very least to acknowledge this in the guidance. The following paper from the Lancet Commission gives the most up to date and comprehensive summary of the evidence around this. Lancet Psychiatry Physical Health Commission Consortium (2025). Holistic prevention and management of physical health side-effects of psychotropic medication: second report of the Lancet Psychiatry Physical Health Commission. <i>The lancet. Psychiatry</i>, 12(9), 673-699. https://doi.org/10.1016/S2215-0366(25)00162-2	Thank you for your comment. We appreciate your point. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20]. NICE has also provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC). This applies to all medicines for NICE guidelines and so recommendations do not state this information every time.

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Royal College of Psychiatrists	Guideline	General		We welcome the focus on “healthy living” as opposed to “lifestyle” interventions. The same point as above applies to people with mental illness and learning disability who have T2DM which is that they struggle to access general population interventions and require reasonable adjustments or bespoke offers of support. Another Lancet Commission paper provides a helpful synthesis of evidence around this. Implementing lifestyle interventions in mental health care: third report of the <i>Lancet Psychiatry</i> Physical Health Commission Teasdale, Scott B et al. The Lancet Psychiatry, Volume 12, Issue 9, 700 - 722	Thank you for your comment. We agree that this is an important area. NICE's guideline on patient experience discusses the need to make reasonable adjustments and has been cross-referred to in this guideline. An extra recommendation about healthy living has been added to the start of the Involving people in medicine discussion section to ensure this is considered during every medicine discussion.
Royal College of Psychiatrists	Scope	003	Section 3.1	We note that the scope document includes within the “special consideration” groups: people with severe mental illness, people with cognitive impairment (for example those with dementia) and people with learning disability. This is to be welcomed as all have either significantly elevated risk, difficulty accessing care and treatment, or both.	Thank you for your comment. We appreciate your feedback
Royal Free London NHS Foundation Trust	Guideline	018	003	Rec 1.8.9 – We welcome the recommendation to commence metformin & SGLT2 inhibitor as dual therapy for all patients.	Thank you for your comment and support of these recommendations.

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Royal Free London NHS Foundation Trust	Guideline	019	009	Rec 1.8.15 - The selection of subcutaneous semaglutide for patients with atherosclerotic CV disease (in triple therapy addition to metformin and SGLT2 inhibitor) is welcome. Oral semaglutide should be included here as well, based on results from the SOUL CVOT published in May 2025. However, the potential use of tirzepatide for CV risk reduction in atherosclerotic cardiovascular disease is not included – should it be acknowledged if this is because data from the SURPASS-CVOT was not available at the time of evaluation?	Thank you for your comment and providing information about interesting studies. Subcutaneous semaglutide was the only GLP-1 receptor agonist or related product that we received sufficient evidence to review that showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather than tirzepatide and oral semaglutide for people with atherosclerotic cardiovascular disease at this time. Tirzepatide has evidence for glycaemic and weight management benefits, but not for cardiovascular and renal protection currently. We have acknowledged that the SURPASS-CVOT study is not included in this review due to it not being fully published and not having access to the data which would allow for full assessment of the cardiorenal benefits. . We have added the SOUL trial to the guideline, but this did not change the results of the review.
Royal Free London NHS Foundation Trust	Guideline	020	013	Rec 1.8.21 – it is disappointing that people living with obesity, T2D and co-morbidities related to obesity such as dyslipidaemia, hypertension, CV disease, sleep apnoea will not be prioritised for early GLP-1R agonist use based on their cost-effectiveness modelling. Indeed, this is inconsistent with NICE guidance TA1026.	Thank you for your comment. We appreciate that this is disappointing. The type 2 diabetes guideline provides recommendations for when the primary treatment aim is for providing cardiovascular and renal protection and glycaemic benefits, and secondarily for weight loss benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the relevant technology

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					appraisals. Edits have been made to the guideline to reinforce this.
Royal Free London NHS Foundation Trust	Guideline	021	008	Rec 1.8.24 - consider adding canagliflozin as this is licensed for CKD in T2D and has evidence for benefit in CREDENCE, CANVAS and CANPIONE clinical trials. The latter trial is less publicised, yet it indicates benefit on albuminuria and eGFR slope in earlier CKD with microalbuminuria.	Thank you for your comment. The recommendations for chronic kidney disease have been updated to take into account the relevant cautions around use for people with chronic kidney disease for each SGLT-2 inhibitor. All SGLT-2 inhibitors are recommended for people with an eGFR above 30 ml/min/1.73 m ² . Only dapagliflozin and empagliflozin are recommended for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² following the technology appraisals for chronic kidney disease and current licencing in the SPC for each product regarding initiation of treatment.
Royal Free London NHS Foundation Trust	Guideline	022	003	Rec 1.8.28 - The guideline advises to use a DPP-4 inhibitor after SGLT2 inhibitor in CKD (despite lack of data on renal protection) but makes no mention of GLP1-R agonists in this group despite increasing evidence of renal protection with semaglutide (FLOW study) and safety for hypoglycaemia vs insulin	Thank you for your comment. is based on providing glycaemic reduction effects rather than renal protection as, unfortunately, we did not find evidence of other medicines that can provide this while also being cost effective. The rationale for this can be read in the rationale and impact section. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness. The population was people living with obesity living with CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (following recommendations about prioritising how to manage comorbidities).

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Royal Free London NHS Foundation Trust	Guideline	028	013	Rec 1.8.51 - Should a minimum BMI be suggested for initiation of GLP1-R agonist on basis of safety? (as per comment 2 above)	Thank you for your comment. The BNF advises that low appetite and weight reduction are side effects of GLP-1 receptor agonists and tirzepatide. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further information is provided in Developing NICE guideline: the manual [PMG20] . NICE has also provided information around making decisions using NICE guidelines . This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC) . We have added a recommendation to state that GLP-1 receptor agonists should be stopped if people become underweight.
Royal Free London NHS Foundation Trust	Guideline	029	011	Rec 1.8.54 - The removal of the arbitrary BMI threshold >35 kg/m ² for the initiation of GLP-1R agonists is welcomed but guidance is needed regarding safe BMI for use. There is no data for CV	Thank you for your comment. The BNF advises that low appetite and weight reduction are side effects of GLP-1 receptor agonists and tirzepatide. Healthcare professionals should use NICE guidelines alongside their own judgement and discussions with people using the services. Further

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				protection for patients BMI <25 kg/m ² and potential for harm if BMI <20 kg/m ²	information is provided in Developing NICE guideline: the manual [PMG20] . NICE has also provided information around making decisions using NICE guidelines . This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC) . We have added a recommendation to state that GLP-1 receptor agonists should be stopped if people become underweight.
Royal Free London NHS Foundation Trust	Guideline	029	011	Rec 1.8.54 - Where the guideline states 'GLP-1R agonists' this does not explicitly include tirzepatide (dual GIP/GLP-1R agonist) although the data shows enhanced efficacy and cost-effectiveness in type 2 DM. We would be grateful if this could be clarified. This document is an ideal opportunity to provide guidance on the optimal selection of GLP-1R agonist agent.	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist and tirzepatide" to show the role of tirzepatide in this population.
Royal Free London NHS Foundation Trust	Guideline	030	013	Rec 1.8.57 – There is no clarity of when tirzepatide might be used in preference to other GLP-1R agonists.	Thank you for your comment. The wording has now been changed to say "GLP-1 receptor agonist and tirzepatide" to show the role of tirzepatide in this population.
Royal Free London NHS Foundation Trust	Guideline	031	011	Rec 1.8.59 – suggest that the section on frailty needs improving with more clarity, especially for the non-expert.	Thank you for your comment. We agree that this needed more clarity. Examples have been added to which adverse events are considered important.
Royal Free London NHS	Guideline	031	020	Rec 1.8.59 - The recommendation to use insulin and sulphonylureas before considering GLP-1R	Thank you for your comment. The recommendation is a consider recommendation, reflecting the uncertainty and that

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Foundation Trust				agonists in frail patients who are overweight seems contradictory. Extensive data from GLP-1R agonists suggests that functional scores are improved with weight loss, notwithstanding concerns that weight loss entails loss of muscle mass. Moreover, this recommendation exposes a very vulnerable group to the risk of hypoglycaemia and falls from the use of insulin or sulphonylureas. The potential for loss of lean body mass and use of GLP-1R agonists in underweight or anorexic frail patients should clearly be avoided however.	each medicine should be considered on a case by case basis for each person. There will be some people in this group where specific treatments are not appropriate, while there are others where it is. A warning is provided in the next recommendation about the risk of hypoglycaemia and falls. The presumption is that prescribers are aware of the guidance in the BNF and product characteristics of the medicines that they are prescribing.
Royal Free London NHS Foundation Trust	Guideline	034	009	Rec 1.8.67 - The section on insulin-based treatments appears focused on up-titration, without reference to preference for substitution of insulin with better therapies once hyperglycaemic symptoms are controlled. There could be a missed opportunity here to educate that insulin and sulphonylureas should be considered treatments of last resort for Type 2 diabetes, as they are obesogenic, stimulate appetite and worsen insulin resistance. If they are needed, insulin therapies should ideally be used on temporary basis only, unless demonstrably in late-stage insulin-deficiency, pregnancy/preconception, time-limited steroid treatment, or renal failure. Wherever possible,	Thank you for your comment. We have added reference to trying different types of insulin into the recommendation.

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				transition to weight-neutral therapies with cardiovascular benefit should be preferred, together with provision of adequate dietary advice.	
Teva UK	Guideline	General	General	We welcome the opportunity to respond to the consultation on the updated NICE guideline NG 28 "Type 2 diabetes in adults: management". We are encouraged that the guideline reflects this growing body of evidence and provides a clear framework for earlier and broader treatment use. We believe this direction aligns closely with the government's priority shifts particularly: From treatment to prevention: Optimising treatment earlier in the disease course can delay deterioration and reduce the burden of acute care, as is detailed in the guidance and economic report.	Thank you for your comment. We appreciate your feedback.
Teva UK	Resource impact template	General		The recent launch of generic dapagliflozin will support the NHS in delivering high-value care, ensuring sustainability and equity of access while maintaining robust clinical outcomes. The acquisition cost savings to the NHS the advent of generic versions of branded medicines bring, can be re-invested into supporting systems to mitigate the cost implications of implementing the guidelines. NICE should encourage commissioners in considering how they can formalise re-investing savings into optimising care for these patients as generics become available. We are pleased to see the resource impact template include a savings	Thank you for your comment.

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				calculator for systems to use when reviewing the impact of implementing the guideline. Teva UK welcomes the role that NICE can play in optimising the use of off-patent (and soon to be off-patent) treatments. The availability of off-patent treatments can significantly improve cost effectiveness that ultimately enable and improve population-level outcomes.	
UK Clinical Pharmacy Association	EHIA	General		Given the committee were presented with real world evidence that showed that SGLT-2 inhibitors are under-prescribed, particularly to women and older people, and to people from some ethnic backgrounds should this be woven throughout the guideline? There is a section on early onset type 2 diabetes, is there the opportunity to highlight health inequalities? Additionally, given there are specific recommendations for CGM monitoring (1.7.26) "Commissioners, providers and healthcare professionals should address inequalities in CGM access and uptake by monitoring who is using CGM, identifying groups who are eligible but who have a lower uptake, making plans to engage with these groups to encourage them to consider CGM", is there the opportunity to consider similar	Thank you for your comment. The committee was in agreement with your suggestion. We have added a recommendation to capture this in the section 'Addressing inequalities in use of SGLT-2 inhibitors'.

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				recommendations for SGLT2i monitoring given the EHIA and SGLT2i uptake report?	
UK Clinical Pharmacy Association	Health economic analysis			Tirzepatide is not considered in the economic analysis. Semaglutide (oral) considers the previous formulation rather than Rybelsus 2.0.	Thank you for your comment. The committee reviewed the evidence for the cost-effectiveness of tirzepatide for managing type 2 diabetes, as outlined in NICE TA924. The committee amended their recommendations to include tirzepatide wherever the class of GLP-1 receptor agonists are included. There is no difference in treatment effects or adverse event profiles between the old and new formulations of oral semaglutide. The pricing for the new formulations has not yet been made publicly available. If the price is equivalent to that of the old formulation, the cost-effectiveness would remain unchanged. However, if the new formulation is priced lower, we would revisit its cost-effectiveness and reconsider its position within the treatment pathway.
UK Clinical Pharmacy Association	Resource impact template	General		The resource impact tool gives modelling for GLP-1 RAs for ASCVD and early onset. Is there modelling for impact in obesity?	Thank you for your comment. We have focused our workings on the initial treatments where significant resource impact is expected. The recommendation for GLP-1 receptor agonists for those with obesity are consider recommendations when further treatment may be needed.
UK Clinical Pharmacy Association	Visual summary			Under column CKD, is there the opportunity to mention that glucose lowering effect is reduced if eGFR <45mls/min and other agents may need to be considered in addition	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information, users should refer to the rationale and impact sections of the guideline

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UK Clinical Pharmacy Association	Visual summary	General		States "at each point reinforce advice about diet and behaviour change"- opportunity to include healthy living	Thank you for your comment. This has now been changed to diet and healthy living.
UK Clinical Pharmacy Association	Visual summary	General		The algorithm implies offering agents together, however the guideline states to confirm tolerability before introducing the next agent, this may lead to confusion if not read in conjunction	Thank you for your comment. The visual summary has been updated to make it clear that drugs are to be initiated sequentially.
UK Clinical Pharmacy Association	Visual summary	General		In the review medication section there is no mention of making sure ineffective medications are stopped other than with GLP_1s and SGLT2's this may lead to in-effective medicines such as DPP4's being continued without reason.	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. For further information about benefits, risks and cost effectiveness, users should refer to the rationale and impact sections of the guideline. Whilst the benefits of DPP-4 inhibitors are not as pronounced as GLP-1s and SGLT2s, they are associated with fewer side effects so may be more appropriate for people with multiple comorbidities. They may also be more appropriate for some populations such as those with frailty and some people with CKD. Stopping DPP-4s would be based on shared decision making. There is further information for users in NICEs information on prescribing medicines.
UK Clinical Pharmacy Association	Visual summary	General		There is a concern that the first column 'no relevant comorbidities' downplays people who are at high risk of CVD and therefore should be offered an SGLT2i with proven cardiovascular benefit.	Thank you for your comment. The committee agree that it is very unlikely that anyone with type 2 diabetes is actually at low cardiovascular risk, and this has been highlighted in the rationale for Initial medicines: People with type 2 diabetes and no relevant comorbidities. The title of 'no relevant comorbidities' just shows the treatment that people should be

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					offered if they do not have obesity, chronic kidney disease, early onset type 2 diabetes, heart failure, atherosclerotic cardiovascular disease and frailty. The committee chose not to state SGLT-2 inhibitor with a proven cardiovascular benefit because they agreed that all the drugs in this class have cardiovascular benefits.
UK Clinical Pharmacy Association	Visual summary	General		Under the column CKD, it recommends offering metformin but does not mention dose reduction might be needed depending on renal function	Thank you for your comment. Visual summaries are used for where practice needs to change, a practitioner needs to make quick decisions, or a specific audience needs support in implementing recommendations. However, there is further information about metformin dose reduction in the committee discussion under the section "People with chronic kidney disease and initial therapy: when can metformin and SGLT-2 inhibitor therapy be given?" and in the "Rationale and Impact" section of the guideline.
UK Clinical Pharmacy Association	Visual summary	General		Under the column CKD, there is no reference to the pt being on maximum tolerated dose of ACEi or ARB	Thank you for your comment. Previous recommendations relating to this have been removed for this update because people with chronic kidney disease who are eligible for an SGLT-2 inhibitor (with an eGFR of 20 ml/min/1.73 m ² and above) are discussed in the new medicines recommendations. Stating the maximum tolerated dose of ACEi or ARB is outside the scope of this guideline. Please refer to NICE's information on prescribing medicines .

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UK Clinical Pharmacy Association	Visual summary	General		Tirzepatide is not included within the algorithm, however it is referenced in the guideline: "Tirzepatide is recommended as an option in NICE technology appraisal guidance for some adults with type 2 diabetes when it is insufficiently controlled". There is a concern that this may lead to variation in prescribing.	Thank you for your comment. Tirzepatide has now been included in the guideline in relevant places (see recommendations including "GLP-1 receptor agonists or tirzepatide").
UK Clinical Pharmacy Association	Visual summary	General		Under the obesity column, the algorithm however states: "Consider adding a GLP-1 receptor agonist" but does not reference specific medications within the class based on weight loss efficacy. Table 1 within the guidance (page 92) refers to "consider adding semaglutide for adults with type 2 diabetes who are living with obesity". Additionally, noting the evidence showed that no GLP-1 receptor agonist reached the cost effectiveness threshold in the base-case analysis for people living with obesity but when price of liraglutide reduced by 35% was used in the sensitivity analyses, there was potential for GLP-1 receptor agonists to be cost effective under specific circumstances should this be considered, should reference be made.	Thank you for your comment. This error in Table 1 on page 92 has now been amended. The committee agreed that no GLP-1 receptor agonist should be specified. While liraglutide came out as cost-effective in one sensitivity analysis, the committee agreed that it did not show evidence of clinically important reductions in weight loss and the evidence for cardiovascular and renal protection and glycaemic benefits was stronger with other GLP-1 receptor agonists. Given this, they did not want to make a specific recommendation and agreed it was more appropriate to provide flexibility in this case
UK Clinical Pharmacy Association	Guideline	004	005-010	Care should be planned and delivered by a multidisciplinary team that includes pharmacists with competencies in diabetes medicines	Thank you for your comment. We agree with you that input from a multidisciplinary team is required when initiating antidiabetic medication, especially given we are recommending

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				optimisation and patient education. This aligns individualised care with NG5 which recommends the use of pharmacists for medication reviews and optimisation. Also see Impact of Pharmacists-Led Interventions in Primary Care for Adults with Type 2 Diabetes on HbA1c Levels: A Systematic Review and Meta-Analysis which demonstrates that pharmacist-led diabetes medication reviews in primary care lead to significant improvements in glycaemic control in type 2 diabetes.	initiating multiple therapies at the same time. Healthcare professionals can refer to NICE's Medicines optimisation guideline which highlights the importance of a medication review by a multidisciplinary team including pharmacists, which is referenced within this guideline.
UK Clinical Pharmacy Association	Guideline	007	015-017	NHS type 2 diabetes path to remission is mentioned but it does not mention when referral maybe appropriate and maybe a good opportunity to increase referral to this pathway.	Thank you for your comment. The dietary advice section of the type 2 diabetes guideline (NG28) was out of scope for this medicines update. A cross-reference link has been added to the NHS Pathways to Remission programme which can be used to access eligibility and referral thresholds. A cross reference has also been added to recommendations on low-energy and very-low-energy diets to achieve type 2 diabetes remission which was considered as part of the update of the overweight and obesity management guideline (NG 246).

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UK Clinical Pharmacy Association	Guideline	008	011	The word "tobacco" is hyperlinked, but it may be useful to add for recommendations on smoking cessation	Thank you for your comment. The guideline is called "Tobacco: preventing uptake, promoting quitting and treating dependence" and includes recommendations on smoking cessation. Stating the main word that names the guideline is consistent with NICE writing style. Given the recommendation specifies about wellbeing advice, then this allows people to be linked to the relevant advice through this.
UK Clinical Pharmacy Association	Guideline	008	016	There is a section signposting to guidance for diagnosis and management of hypertension, but there is not a similar section hyperlipidaemia	Thank you for your comment. This is out of scope for the guideline update.
UK Clinical Pharmacy Association	Guideline	014	017	There is no mention of metformin within the list of medications	Thank you for your comment. The purpose of this text is to explain that recommendations have been made at the class level (unless otherwise stated) for DPP4 inhibitors, GLP-1 receptor agonists, sulfonylureas and SGLT-2 inhibitors. Drug-level recommendations have been made for metformin, which is why metformin has not been mentioned.
UK Clinical Pharmacy Association	Guideline	015	010	It might be helpful to include a recommendation around cost if 2 drugs in the same class are appropriate, to choose the one with the lower acquisition cost as stated in the current NG28.	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-

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					2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
UK Clinical Pharmacy Association	Guideline	015	018	Reference to GLP-1 RAs, but not dual GIP/GLP-1RA	Thank you for your comment. The committee have assessed the evidence and have agreed that tirzepatide should be included in the recommendation. Therefore, this has been amended to GLP-1 receptor agonists and tirzepatide.
UK Clinical Pharmacy Association	Guideline	015	018	Discusses GLP-1 receptor agonists in those of childbearing potential. Consider including this information under a separate heading or within the section "assessing risks before starting treatment" to improve flow and readability. Additionally the advice regarding the use of HRT with GLP-1s should be included.	Thank you for your comment. We agree that this information is important. This was viewed as a part of conversation with the person while having a medicine discussion, which should always be considered, regardless of whether you are starting the medicine for the first time. Pregnancy, the chance to become pregnant and breast feeding are not a risk associated with type 2 diabetes while cardiovascular disease, worsening renal disease or frailty are and so are listed under Assessing risk before starting medicines (as the latter is related to determining which treatment pathway to use when choosing

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					medicines, while the former would either be offered the same treatment options or be considered in NICE's diabetes in pregnancy guideline). Therefore, we think this is in the right place currently. As stated in Developing NICE guidelines: the manual, NICE guidelines do not usually include safety information in recommendations. However, they may be included "If there is a significant safety risk and clear evidence that safety advice is not routinely implemented in practice, if the recommendation will not make sense without the information". Healthcare professionals seeking to use HRT for people with menopause associated symptoms should refer to Menopause: identification and management guideline and the British National Formulary for further information on specific medicines
UK Clinical Pharmacy Association	Guideline	016	001	Section title "Hyperglycaemia", we are concerned that this misses the opportunity to highlight that rescue therapy may need to be considered if the person develops osmotic symptoms, and that insulin and/or SUs should be reviewed once the person is no longer symptomatic and consideration of agents that offer with cardio-renal protection	Thank you for your comment. This section was out of scope for the guideline update. This will be highlighted with the surveillance team as an area for potential update in the future.
UK Clinical Pharmacy Association	Guideline	019	005-009	We agree with the recommendation for subcutaneous semaglutide, however, there is evidence to suggest that liraglutide (via LEADER trial), dulaglutide (via REWIND trial) and tirzepatide (via SURPASS-CVOT) also reduce ASCVD events.	Thank you for your comment. Of the trials you mention, only the data from REWIND was included in the analysis for people with atherosclerotic cardiovascular disease. The data from LEADER was included in the analysis for people with higher risk of CVD and people with heart failure, and not enough

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				These should be recommended as an equal choice, or as an alternative for patients unable to tolerate semaglutide, to ensure prescribers are not discouraged from using GLP-1 receptor agonists where appropriate.	evidence was received for the SURPASS-CVOT trial to assess cardiovascular and renal benefits for tirzepatide in people with atherosclerotic cardiovascular disease, Of the GLP-1 receptor agonists and tirzepatide, only subcutaneous semaglutide showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather than tirzepatide, liraglutide and dulaglutide for people with atherosclerotic cardiovascular disease at this time.
UK Clinical Pharmacy Association	Guideline	020	012	People living with obesity. Noting BMI criteria has been removed, should the term be defined within the "terms used in this guideline section" or as per the obesity guideline with reference to "healthy weight". There is a concern that not defining obesity may lead to variations in prescribing. The Tirzepatide TA references BMI.	Thank you for your comment. The sections on initial medicines and treatment options if further medicines are needed for people living with obesity now include cross-references to recommendations on classifying overweight and obesity in NICE's guideline on overweight and obesity management.
UK Clinical Pharmacy Association	Guideline	021	006	People with CKD. Within this section is there the opportunity to mention that glucose lowering effect is reduced if eGFR <45mls/min and other agents may need to be added in addition.	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions

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					from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .
UK Clinical Pharmacy Association	Guideline	021	006	Rather than a DPP4 as 3 rd line should we not consider semaglutide given the recent FLOW trial evidence	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The differences from the KDIGO 2024 guideline are likely as health economics is not considered alongside the clinical evidence when making recommendations. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
UK Clinical Pharmacy Association	Guideline	021	008-010	The CANVAS, CREDENCE and CAMPIONE studies demonstrated reduction in the progression rate of CKD in patients with type 2 diabetes and CKD and should be considered alongside empagliflozin and dapagliflozin in this cohort.	Thank you for your comment. CANVAS and CREDENCE trials were included in this review however CAMPIONE was excluded based on the comparator used in the trial (stated as guideline standard of care only). The recommendations have been expanded to make a class level recommendation for SGLT-2 inhibitors above 30 ml/min/1.73 m ² .

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UK Clinical Pharmacy Association	Guideline	021	016-018	Patients with an eGFR 20-30 cannot take Metformin and the guideline suggests SGLT2 alone, whilst they should be offered this in relation to cardiovascular risk at this eGFR SGLT2's are unlikely to offer any benefit for glycaemic control, should DPP4 or GLP-1 be offered at this stage also.	Thank you for your comment. We agree that this needed adjusting and on reflection, we have amended the recommendations so that a DPP-4 inhibitor is offered for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² so that it can provide additional glycaemic benefits. For people with an eGFR above 30 ml/min/1.73 m ² , metformin is co-prescribed which provides glycaemic benefits, and evidence included in the guideline and in the technology appraisal for dapagliflozin and empagliflozin for chronic kidney disease shows that there can be meaningful HbA1c reductions from SGLT-2 inhibitors at this level. The purpose of prescribing an SGLT-2 inhibitor is for a) cardiovascular and renal protection, b) glycaemia management. Therefore, there are still likely to be benefits in prescribing it though we agree that the benefits are likely to reduce below 45 ml/min/1.73 m ² .
UK Clinical Pharmacy Association	Guideline	022	011-015	The committee should consider advising clinicians on how to risk assess for patients that have 'a level of frailty that places them at risk of adverse events from SGLT2 inhibitors. Not doing so is unlikely to increase uptake of SGLT2 inhibitors in the elderly cohort.	Thank you for your comment. The committee have added specific examples of the adverse events that they are concerned about. They believe that this statement is more specific than providing frailty scale grades as these are often automatically coded and can lead to incorrect assignment of people into groupings, leading to people not receiving treatments that are appropriate for them and creating health inequalities. Therefore, they believe that this is the more pragmatic method of deciding whether treatment is appropriate for someone or not.
UK Clinical Pharmacy Association	Guideline	023	011	States to introduce the medicines one at a time, starting with metformin and checking tolerability. If using an SGLT-2 inhibitor, start this as soon as	Thank you for your comment. The therapy combinations for each population of interest are listed in sequential recommendations with all recommendations regarding

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				metformin tolerability is confirmed. We are concerned that this is not reflected in the algorithm which implies to start together.	introduction of medicines following this information. As all therapy combinations require a stepwise initiation, the recommendations for introducing medicines are listed in a way so as to avoid repetition of the same statements and to avoid confusion. We have added the wording "at the maximum achievable dose" to make it clear when the next medicine should be started. We have made amendments to the visual summary to make this message clear.
UK Clinical Pharmacy Association	Guideline	028	005	People with early onset type 2 diabetes. Recommends "for adults with early onset type 2 diabetes: Offer metformin and an SGLT-2 inhibitor. Consider adding a GLP-1 receptor agonist". Is there the opportunity to expand to include consideration of childbearing potential (and link to guidance)	Thank you for your comment. A recommendation in section Involving people in medicine discussions describes discussing GLP-1 receptor agonists with people of childbearing potential and refers to MHRA guidance on GLP-1 medicines for weight loss and diabetes
UK Clinical Pharmacy Association	Guideline	028	005	People with early onset type 2 diabetes. Opportunity to mention targeted education, T2DAY programme	Thank you for your comment. Targeted education is outside of the scope of this guideline update and so will not be discussed.
UK Clinical Pharmacy Association	Guideline	029	011-016	We recommend rewording from 'consider adding' to 'offer' to reduce cardiovascular risk.	Thank you for your comment. We agree that GLP-1 receptor agonists will also provide cardiovascular and renal protection benefits in this case. However, the majority of GLP-1 receptor agonists were not cost effective leading to uncertainty in the recommendation, which led to the consider adding recommendation, instead of an offer recommendation. The committee have recommended that any GLP-1 receptor agonist or tirzepatide can be considered for people in this population given that all available GLP-1 receptor agonists showed glycaemic benefits and some cardiovascular benefits.

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					The most clinically effective was subcutaneous semaglutide which was slightly over the threshold for cost-effectiveness. On the other hand, liraglutide was cost effective but was less clinically effective. Other GLP-1 receptor agonists and formulations of GLP-1 receptor agonists (such as oral semaglutide) were not cost effective and were comparatively less clinically effective. Tirzepatide was shown to be cost effective in the technology appraisal for people with type 2 diabetes but did not have evidence for cardiovascular and renal benefits, which GLP-1 receptor agonists did have. This produced uncertainty in the evidence. Given this, they made a weaker consider recommendation in this case.
UK Clinical Pharmacy Association	Guideline	044	015-021	Most CGM used now is rt (unless reader required for libre 2+, although this is due to change in the near future) with no added cost than isCGM so not sure what this evidence is based on? Should the guideline be updated to reflect this change.	Thank you for your comment. This rationale discusses evidence in 2022 and is out of scope for this guideline update. The wording is retained to show what was being discussed at the time.
UK Clinical Pharmacy Association	Guideline	092		Within the table it states "consider adding semaglutide for adults with type 2 diabetes who are living with obesity, if: • they have been taking initial therapy for at least 3 months and • further medicines are needed to reach their glycaemic targets and • they are not already taking a GLP-1 receptor agonist. [2025] (1.8.54)". The algorithm however states: "Consider adding a GLP-1 receptor agonist"- should semaglutide be specifically referenced?	Thank you for your comment. Thank you for highlighting this, this has been amended.

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UK Kidney Association	Visual summary			With the publication of the SURPASS CVOT data, tirzepatide we would recommend this needs to be added to the ASCVD pathway	Thank you for your comment. Subcutaneous semaglutide was the only GLP-1 receptor agonist or related product that we received sufficient evidence to review that showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous semaglutide rather than tirzepatide for people with atherosclerotic cardiovascular disease at this time. The SURPASS-CVOT study was not included in the analyses as it has not been published, and insufficient unpublished evidence has been provided for us to do a formal assessment.
UK Kidney Association	Visual summary			In the obesity pathway, it is unclear why only the use of a GLP-1 RA is recommended? With the data from SURPASS 2, tirzepatide should be considered given its superior efficacy in glycaemic control and weight reduction	Thank you for your comment. We agree tirzepatide should be included. The wording has changed to "GLP-1 receptor agonists and tirzepatide" to reflect where tirzepatide is placed in the pathway.
UK Kidney Association	Guideline	021	010	While the recommendation to start patients with Diabetes and CKD on Dapagliflozin and Empagliflozin is welcome, we wonder why Canagliflozin has not been recommended. In addition to Empagliflozin, only Canagliflozin has been shown to have a beneficial effect on 3-point MACE as shown in the CANVAS study. Similarly, CREDENCE trial strongly supports the use of Canagliflozin in patients with diabetes and CKD with proteinuria and therefore should be considered.	Thank you for your comment. The recommendations for chronic kidney disease have been updated to take into account the relevant cautions around use for people with chronic kidney disease for each SGLT-2 inhibitor. All SGLT-2 inhibitors are recommended for people with an eGFR above 30 ml/min/1.73 m ² . Only dapagliflozin and empagliflozin are recommended for people with an eGFR between 20 ml/min/1.73 m ² and 30 ml/min/1.73 m ² following the technology appraisals for chronic kidney disease and current licencing in the SPC for each product regarding initiation of treatment.

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UK Kidney Association	Guideline	021	018	Recommend making comment that once started on Empagliflozin evidence from EMPA-KIDNEY shows benefits continuing these agents beyond eGFR <20mls/min/1.73m ² even if a further agent is added in view of it's cardiovascular benefits that also applies to Dapagliflozin and Canagliflozin with the latter requiring dose adjustment required at lower GFR. Note Empagliflozin can be commenced at GFR 20mls/min/1.73m ² that is not reflected in the guidance.	Thank you for your comment. The expectation is that prescribers have knowledge of the BNF and the characteristics of the medicines that they are prescribing, and that these state when SGLT-2 inhibitors can be initiated and should be stopped. This section only discusses about the initiation of medicines not about reviewing them. The current guidance is that dapagliflozin and empagliflozin can be started at lowest at an eGFR to 20 ml/min/1.73 m ² . Therefore, they are recommended as such.
UK Kidney Association	Guideline	027	002	With the tirzepatide SUMMIT trial, why not include tirzepatide in those with HFpEF?	Thank you for your comment. The SUMMIT trial discusses tirzepatide for people with heart failure living with obesity who don't necessarily have type 2 diabetes, rather than people with heart failure, living with obesity who all have type 2 diabetes. Therefore, it does not fulfil the criteria to be included in the guideline update.
UK Kidney Association	Guideline	028	004	With the publication of the SURPASS CVOT data, tirzepatide should be added to the ASCVD pathway.	Thank you for your comment. The SURPASS CVOT trial has not been published in full as of this time. Unfortunately, we have not been provided with a full manuscript and so were unable to review it for inclusion in this guideline. Subcutaneous semaglutide was the only GLP-1 receptor agonist or related product that we received sufficient evidence to review that showed clinical and cost effectiveness to indicate cardiovascular and renal protection, glycaemic and weight management benefits for people with type 2 diabetes. Therefore, we have only recommended subcutaneous

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					semaglutide rather than tirzepatide for people with atherosclerotic cardiovascular disease at this time.
UK Kidney Association	Guideline	031	001	We welcome the inclusion of chronic kidney disease (CKD) as an important factor in treatment decisions. This reflects the high cardiovascular and renal risk in this population and aligns with current evidence on the need for tailored interventions. We welcome the recommendation in relation to the use of SGLT2i in patients with CKD. We are concerned about the exclusion of GLP-1 receptor agonists as a second-line option for people with type 2 diabetes and CKD. Recent evidence from the FLOW trial demonstrates that semaglutide significantly reduces the risk of major kidney outcomes and cardiovascular events in this population. Semaglutide reduced the composite risk of kidney failure, substantial loss of kidney function, and death from kidney or cardiovascular causes by 24%, slowed eGFR decline, and reduced all-cause mortality by 20%.	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness. The population was people living with obesity living with CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists or tirzepatide for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
UK Kidney Association	Guideline	031	003	Should this not say appropriate dosing according to eGFR?	Thank you for your comment. The presumption is that prescribers are aware of the guidance in the BNF and product characteristics of the medicines that they are prescribing. Therefore, this is only specified where this is not in line with normal practice.
UK Kidney Association	Guideline	032	020	If someone has a high HbA1c the addition of insulin, would not stop the continuation of oral	Thank you for your comment. The committee consider that, in most cases, continuation of medicines that are solely to

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				agents – e.g. pioglitazone, or SU, the caveat to this is whether the clinician assesses there may be the added risk of hypoglycaemia in that individual. It is important to allow tailored therapy/personalised medicine.	manage hyperglycaemia (pioglitazone, sulfonylureas) would likely not add benefit. Therefore, the committee have not changed this recommendation. As with all NICE recommendations, they are recommendations rather than absolute rules and we agree that personalised medicine is important.
UK Kidney Association	Guideline	034	017	It is unclear why there has been no suggestion / recommendation for Fixed Dose combination of GLP- 1 and long acting insulin?	Thank you for your comment. Fixed dose combinations of GLP-1 receptor agonists and long acting insulins were reviewed, and it was agreed that there was insufficient evidence of benefit compared to placebo in terms cardiovascular benefits to recommend these.
UK Kidney Association	Guideline	036	005	The gastroparesis section should have comments about perioperative diabetes care – in particular that where possible, shared decision making about stopping the drug should be made between the anaesthetist and patient, and that in general, GLP-1 agents should <u>not</u> be stopped, and SGLT2 inhibitors <u>should</u> be stopped the day before a procedure – in line with CPOC guidance (Perioperative Care of People with Diabetes Undergoing Surgery Centre for Perioperative Care). That if gastroparesis is suspected that mitigation strategies should be used – e.g. off label preoperative low dose (0.5mg/kg) IV erythromycin, point of care gastric ultrasound and anaesthetic techniques to reduce the risk of pulmonary aspiration.	Thank you for your comment. This section was out of scope for the guideline update.

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UK Kidney Association	Guideline	052	002	Now that dapagliflozin is generic, with comparable CVOT / HF / CKD data to empagliflozin, will the 'lowest acquisition cost' clause be reinserted?	Thank you for your comment. We agree that acknowledging this clinical reality is important to ensuring the guideline reflects what matters most to healthcare professionals doing their day to day work. As a result, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
UK Kidney Association	Guideline	057	005	Previous NICE guidance has often said 'agent with the cheapest acquisition cost' – here for GLP-1's, with CVOT data, it is likely to be generic liraglutide. Are NICE saying do not use this, but use semaglutide or tirzepatide? (mentioned on page 80 line 22). This needs clarification.	Thank you for your comment. For people with type 2 diabetes and atherosclerotic cardiovascular disease, the only cost-effective GLP-1 receptor agonist was subcutaneous semaglutide, which is why this GLP-1 receptor agonist was specified for this population. This is because the health economic analysis also takes into

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					account the cost-saving implications of a reduction in adverse events. Elsewhere in the guideline where a recommendation for “GLP-1 receptor agonist or tirzepatide” has been made, we have added wording to recommend considering the lowest acquisition cost medicine when more than 1 medicine from the same drug class is equally suitable for the person (taking into account multiple factors, such as administration cost, dosages, price per dose and commercial arrangements). To note, the committee considered dapagliflozin to be equally suitable as other SGLT-2 inhibitors. The committee did not consider liraglutide to be equally suitable as other GLP-1 receptor agonists, and so other GLP-1 receptor agonists should be considered based on their clinical effectiveness. Please note that, in general all NICE guideline recommendations for interventions support that the lowest cost medicine should be used unless otherwise specified (if there are multiple equally suitable choices). In this case, particularly important cost savings can be achieved given the significant price difference between most SGLT2 inhibitors and SGLT2 inhibitors that have a generic form (in February 2026, the only generic was dapagliflozin).
UK Kidney Association	Guideline	083	012	With the epidemiologically increased risk of distal forearm fractures in pioglitazone users (e.g. Pioglitazone and Risk for Bone Fracture: Safety Data From a Randomized Clinical Trial - PMC), should it be recommended in those with frailty?	Thank you for your comment. The committee have agreed that pioglitazone should be included as an option, but have used a weak consider recommendation to show that it may not be appropriate for everyone and it should be considered on a case by case basis amongst the other treatments in that

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					section. We have added information about the risk of fractures into the rationale for this section.
UK Kidney Association	Guideline	084	021	BNF prices states that branded lantus is 30% cheaper than abasaglar, so this statement is currently incorrect	Thank you for your comment. This section is out of scope for consultation as it is a historical reference to the previous recommendations. However, the statement is still appropriate as it states that if a biosimilar is available, then (the medicine) with the lowest cost should be used. If that is not the biosimilar, then the branded formulation can be used. Therefore, this does not need to be edited to maintain the meaning of the recommendation.
University College London NHS Foundation Trust	Guideline	018	002	We agree with the strategy advocating for sodium-glucose co-transporter-2 inhibitors (SGLT2i) as a first-line treatment, in combination with metformin, for individuals with type 2 diabetes (T2DM) without significant comorbidity. This approach would expand the number of people eligible for SGLT2i therapy and introduce this drug class much earlier in the treatment algorithm for T2DM. However, we note that this proposed use differs substantially from the populations studied in the randomised controlled trials (RCTs) that first established the benefits of SGLT2i. For example, the seminal EMPA-REG trial demonstrated that empagliflozin significantly reduced mortality in people with T2DM and established atherosclerotic cardiovascular disease. By contrast, the draft recommendation would introduce SGLT2i much	Thank you for your comment. Thank you also for the information about your reassuring study findings given the conclusions from the committee recommendations. The guideline committee made the recommendation based on a combination on the RCT evidence, their knowledge of wider evidence, lived experience, economic modelling considering the context of use and resource impact. Considering all of this together, they agreed the recommendations. This study would not be included in this review due to only RCTs being eligible for inclusion in the protocol. However, the findings are appreciated and encouraging.

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				earlier in the disease course, among patients who differ from those recruited into RCTs. This divergence between RCT evidence and the proposed broader application raises questions about the real-world effectiveness of SGLT2i, particularly among patient groups under-represented in RCTs. The draft recommendation is based largely on network and pairwise meta-analyses of antidiabetic therapies (page 49, lines 1–3). While valuable, such analyses are ultimately derived from RCTs, which often lack generalisability to the populations treated in routine clinical practice. To address this gap, we conducted a study evaluating the real-world effectiveness of empagliflozin in UK primary care (THIN database) using a trial emulation framework. We replicated the EMPA-REG trial and demonstrated that the population currently receiving empagliflozin in practice differs substantially from the original trial population. Importantly, when we relaxed the stringent eligibility criteria used in EMPA-REG, the treatment effect in real-world populations remained consistent, showing strong evidence of a mortality benefit regardless of RCT eligibility status.	

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				These findings provide reassuring real-world evidence that the benefits of SGLT2i extend to patients under-represented in traditional RCTs. They augment existing trial and meta-analysis evidence and directly support a universal SGLT2i strategy in T2DM management. The robustness of our findings was confirmed through sensitivity analyses addressing unmeasured confounding. This work has been presented at the local Clinical Pharmacology departmental meeting and is currently being prepared for publication, with a pre-print available at: https://www.medrxiv.org/content/10.1101/2025.09.17.25335885v1	
University College London NHS Foundation Trust	Guideline	050	006-007	We note the concern in the guideline document that no direct evidence was identified for the use of SGLT2i in people with type 2 diabetes (T2DM) at low cardiovascular disease (CVD) risk. The committee has proposed extrapolating evidence from higher-risk groups, reasoning that as people with T2DM age, their lifetime CVD risk and QRISK3 scores inexorably increase. Our trial emulation study [https://www.medrxiv.org/content/10.1101/2025.09.17.25335885v1]	Thank you for your comment. Thank you for your information about your reassuring study findings given the conclusions from the committee recommendations. The guideline committee made the recommendation based on a combination on the RCT evidence, their knowledge of wider evidence, lived experience, economic modelling considering the context of use and resource impact. Considering all of this together, they agreed the recommendations. This study would not be included in this review due to only RCTs being eligible for inclusion in the protocol. However, the findings are appreciated and encouraging.

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				17.25335885v1, under review BMJ Open Diabetes Research & Care] provides relevant real-world evidence to support this approach. Among current empagliflozin users, many of whom did not have established CVD, we found the mortality benefit of empagliflozin to be consistent across a broad population. In fact, only 25–30% of participants in our study had established CVD. These findings are reassuring and support the extrapolation of RCT evidence from high-risk to lower-risk groups, reinforcing the case for broader use of empagliflozin in T2DM management.	
University College London NHS Foundation Trust	Guideline	052	013-015	We note that the guideline documents suggest broader access to SGLT2i may result in long-term drug costs being partially offset by fewer people requiring treatment for atherosclerotic cardiovascular disease. In real-world UK primary care data (N= 62,503), we observed a significant improvement in all-cause mortality for empagliflozin users compared with DPP-4i (https://www.medrxiv.org/content/10.1101/2025.09.17.25335885v1). It is likely that the benefits of SGLT2i extend beyond reducing atherosclerotic cardiovascular events, and confer an all-cause mortality advantage. However, the downstream effects of increasing utilisation of SGLT2i on	Thank you for your comment. The evidence in this review highlights the benefits of using SGLT-2 inhibitors for most people in reducing lifetime risks of cardiovascular events and associated mortality. We acknowledge the importance of starting a SGLT-2 inhibitor following the optimisation of metformin to reduce the risk of diabetic ketoacidosis and also the importance of sick day rule and assessing risk before starting medicines. Additionally, the committee added specific examples of the adverse events that they are concerned about and have provided a more pragmatic method of deciding whether treatment is appropriate for someone or not.

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				practice and wider systems are difficult to predict, especially in context of increasing longevity of users. There may be less major adverse cardiovascular events, but increased health utilisation may arise from other causes, for example, falls or acute illnesses.	
University Hospital Plymouth NHS Trust	Guideline and visual summary	General		Glycaemic targets currently not present on the visual summary "Type 2 diabetes in adults: choosing, reviewing and changing medicines"-as this is the part most likely to be referenced by care givers in primary care having targets in the visual summary would be important	Thank you for your comment. In the medicines section and update, the committee did not agree that arbitrary discontinuation targets should be set and that these should be agreed with the person with type 2 diabetes to help aid concordance and achieve good outcomes. Therefore, this is in keeping with the medicines update.
University Hospital Plymouth NHS Trust	Guideline and Visual summary	General		The visual summary is well laid out but there appears to be no reference to those with type 2 DM who are at high CV risk due to combination of other risk factors-this group may have a BMI of 27 but not have CKD or heart failure or established CVD and be diagnosed at say age 42 so not technically young onset. The could have comorbidities though such as hypertension and hyperlipidaemia. This would appear to be a group who might require specific attention unless the committee feels that by adding SGLT2 as initial therapy they are covered. I wondered if consideration had been given to those in this group and the evidence for the benefit of GLP-1 (specifically semaglutide) on CV outcomes	Thank you for your comment. The committee considered people with type 2 diabetes and no relevant comorbidities to be at high cardiovascular risk based on their diagnosis of type 2 diabetes alone. Based on this increased cardiovascular risk, the committee recommended initial treatment with an SGLT-2 inhibitor in this population. The committee did not recommend GLP-1 receptor agonist treatment in people with type 2 diabetes and no relevant comorbidities as GLP-1 receptor agonists were not cost-effective in this population.

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University Hospital Plymouth NHS Trust	Guideline and visual summary	General		We see a lot of MASLD-this does not get mentioned as comorbidity but might significantly alter our approach to therapy-there seems great value in adding this to the list of comorbidities and deciding if this would alter the therapeutic approach (especially in those with MASLD but BMI < 30)	Thank you for your comment. The metabolic dysfunction-associated steatotic liver disease (MASLD) guideline is currently being updated with the expected publication date December 2026.
University Hospital Plymouth NHS Trust	Guideline and visual summary	General		In the guidelines reference is made to GLP-1 receptor agonist therapy but dosage to aim for is not delineated. Come of the evidence used to support the earlier use of GLP-1 in ASCVD or obesity with specific reference to semaglutide has included trials with the 2.4 mg weekly dose-I think that it is therefore key that dosing recommendations are added here with the rationale	Thank you for your comment. A dose clarification has been added to the visual summary stipulating that subcutaneous semaglutide (Ozempic), up to 1 mg per week is to be used. Additional information regarding the reasoning behind the dose clarification can be found in the rationale and impact section. .
University Hospital Plymouth NHS Trust	Guideline	006	007	We seem to have no definition of what a "healthcare professional with specific expertise and competencies in nutrition" constitutes. This advice is to be individualised and ongoing and in most places will be from a practice nurse many of whom may not have specific training here-is this what is envisaged or could there be more precision in this term	Thank you for your comment. This is out of scope for the guideline update.
University Hospital Plymouth NHS Trust	Guideline	010	016-018	Why, if target HbA1c is 53 is 58 used as the threshold for intervention? Surely this contributes to inertia	Thank you for your comment. This section was amended for updating language only and was out of scope for this guideline update. The committee agreed that these targets should be individualised. This is discussed in the recommendations after this that mention NICE's patient decision aid on type 2 diabetes: agreeing someone's blood glucose (HbA1c) target.

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					This has been reinforced later in the guideline when discussing reviewing medicines to make this clearer. The committee does not want to set values for HbA1c as they do not have evidence to support this and do not believe this will be the best for care. Given this is a personalised goal it is up to the person with diabetes and their healthcare professional to decide whether they want to expand that range. The patient decision aid related to the guideline is available to support this.
University Hospital Plymouth NHS Trust	Guideline	011	021-029	Guidelines do not suggest that routine monitoring of capillary glucose is of benefit. Whilst there are some studies specifically looking at self-monitoring of blood glucose as an issue it strikes me that all major studies of all the therapeutic interventions listed and all the large outcome studies such as UKPDS used self -monitoring of capillary glucose in a structured manner to support treatment decisions- from my reading of the literature there is therefore no evidence of a benefit from a pharmaceutical intervention in type 2 diabetes management without the support of capillary glucose monitoring-I know this seems contentious and have debated with colleagues but if NICE guidelines are to be evidence based then surely the evidence for the utility of the therapeutic interventions should extend to the manner in which they were used in these studies and how they were titrated	Thank you for your comment. This section is out of scope for the guideline update.
University Hospital	Guideline	027	002-013	Given evidence base for semaglutide at high risk for CV disease with and without DM with lower BMI	Thank you for your comment. On reviewing stakeholder feedback and the evidence, we have since removed this

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Plymouth NHS Trust				cutoffs than 30 I am unclear why GLP-1 are only recommended in heartfailure with obesity rather than overweight or obesity-is this being re-evaluated	recommendation given the limited evidence specific to the doses licensed for people with type 2 diabetes and the limited evidence for people with heart failure. However, people with type 2 diabetes and heart failure can still access GLP-1 receptor agonists and tirzepatide as further treatment for reaching their glycaemic targets if they also are living with obesity if they and their healthcare professional agree that is appropriate. If aiming primarily for weight management, please see NICE's guideline on overweight and obesity management.
University Hospital Plymouth NHS Trust	Guideline	029	011-016	It appears as if the NICE guidelines is suggesting GLP-1 first then only consider Tirzepatide subsequently if fulfilling criteria and perhaps insufficient response given the way this section is set out-if this is so then the choice of semaglutide over Tirzepatide in this group and the rationale should be mad explicit because the current guidance for Tirzepatide would cover many in this group as 4 th line-so clarity on the progression of therapies here is key. Given cost implications going sequentially here from cheaper GLP-1 to Tirzepatide subsequently seems sensible. There is nothing on semaglutide dosing and I am unclear if semaglutide up to 2.4 mg weekly could be used under the direction in this section and perhaps this clarification would also be helpful	Thank you for your comment. The recommendations have now changed to "GLP-1 receptor agonists and tirzepatide" bringing tirzepatide in line with GLP-1 receptor agonists. Semaglutide dosing has been clarified for other places where subcutaneous semaglutide (Ozempic), up to 1 mg per week is recommended (the maximum dose currently available licensed for people with type 2 diabetes). In the type 2 diabetes guideline, treatments are primarily being provided to achieve cardiovascular and renal protection and glycaemic benefits. Weight reduction effects may be present as beneficial side effects of some treatments, but not the primary aim as treatments may not be meeting the dose or formulation requirements for this. and secondarily for weight loss benefits. If the aim is primarily for weight loss benefits, then we recommend referring to NICE's guideline on overweight and obesity management, which refers to the

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					relevant technology appraisals. Edits have been made to the guideline to reinforce this. Given this, the doses and preparations for type 2 diabetes should be used when using the type 2 diabetes guideline recommendations.
University Hospital Plymouth NHS Trust	Guideline	031	001-009	People with CKD have high risk of CV disease and there are data from the FLOW study (NEJM 2024) suggesting benefits in terms of CV and renal outcomes so I am surprised that semaglutide is not recommended in this group or a subgroup (without requiring obesity as no BMI limit in the study)-the summary of the rationale does not mention the FLOW study or GLP-1 as if not relevant and I would suggest reconsideration	Thank you for your comment. While the FLOW trial showed clinically important benefits in renal protection, this did not correspond to cost effectiveness where subcutaneous semaglutide was not cost-effective in the economic model. The population was people living with obesity and CKD stage 3a. Given this, the committee agreed that it should not be recommended for people with chronic kidney disease, but if people are living with chronic kidney disease and obesity, then there is no reason that they cannot access GLP-1 receptor agonists for the management of type 2 diabetes and obesity if they require further management to reach glycaemic targets (as per guidance about choosing which comorbidity to manage).
University of Leicester	Guideline	General	General	There is limited guidance included in the current draft of the 'Type 2 diabetes in adults: management' August 2025 draft regarding the prescription of SGLT2 inhibitors in those with type 2 diabetes and diabetes-related foot disease (DFD) or peripheral arterial disease (PAD). There is also no mention of SGLT2 inhibitors in the NICE guideline on diabetic foot problems.	Thank you for your comment and for sharing this interesting research. As you have specified, this research would not fall within the review protocol as it did not include the outcome of amputation due to the need to prioritise outcomes given the size of the dataset. We are glad that our recommendations are mostly consistent with the points that you have raised. Regarding people with diabetic foot disease, under NICE's guideline on diabetic foot disease, their care should involve a

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				People with DFD are at high risk for lower-extremity amputation (LEA) and death. Cardiovascular disease (CVD) is the leading cause of death in DFD, with 50% 5-year mortality in those with DFD due to CVD and infection. People with DFD are also at an increased risk for adverse renal outcomes. The Canagliflozin Cardiovascular Assessment Study (CANVAS) study, which investigated the effects of treatment with canagliflozin on cardiovascular, renal and safety outcomes in those with type 2 diabetes, identified an unexplained increased risk of minor amputation in the intervention arm. Cohort studies have also identified increased amputation risk with canagliflozin, whilst studies of other SGLT2 inhibitors (empagliflozin, dapagliflozin and ertugliflozin) have demonstrated no increased LEA risk when compared to placebo in those with type 2 diabetes. Therefore, despite the cardiorenal benefits of SGLT2 inhibitors, concerns about amputation risk in those with DFD remain, and is impeding the completion of further randomised controlled trials in this area. In the absence of such evidence, we have completed two studies; a meta-analysis of risk of lower extremity amputation in patients with type 2	diabetologist who can advise on this scenario as this goes beyond the standard advice provided in the guideline. This guideline is cross referred to within the type 2 diabetes management guideline. NICE recommendations should be implemented by a healthcare professional with appropriate expertise and training. NICE has provided information around making decisions using NICE guidelines. This states that Healthcare professionals should take note of the contraindications, warnings, safety recommendations and any monitoring requirements for the medicine. These are explained in the SPC for the medicine, the British National Formulary (BNF) or British National Formulary for Children (BNFC) and so it would be expected that the healthcare professional considers the risk of amputation when discussing medicines with the patient.

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				diabetes mellitus and peripheral arterial disease receiving sodium-glucose cotransporter-2 inhibitors versus other medications, and a Delphi-based expert consensus survey, including input from both experts in primary and secondary care management of type 2 diabetes (including the National Director for Diabetes and Obesity) and patients with lived experience, investigating the use of SGLT2 inhibitors in people with diabetes-related foot disease. The meta-analysis found no statistically significant increase in risk of LEA for people with type 2 diabetes and peripheral artery disease prescribed SGLT2 inhibitors compared to GLP-1RAs. Risk of LEA also appeared to be significantly lower in people with type 2 diabetes treated with SGLT2 inhibitors compared to DPP-4 inhibitors, and significantly higher in SGLT2 inhibitors compared to sulphonylureas. The global Delphi study found that experts believed that: SGLT2 inhibitors should be prescribed to those with type 2 diabetes (regardless of ulceration status) with concurrent heart failure and/or chronic kidney disease; those with a previous healed ulcer or amputation should be prescribed SGLT2 inhibitors; SGLT2 inhibitors per se do not increase amputation risk, and canagliflozin should be avoided in this group.	

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				The meta-analysis can be found here: https://pubmed.ncbi.nlm.nih.gov/38558251/ The Delphi study can be found here: https://pubmed.ncbi.nlm.nih.gov/40495570/ Taken together, and in the absence of further randomised controlled trials, these findings highlight that SGLT2 inhibitors, other than canagliflozin, are generally safe in those with type 2 diabetes and DFD. Given that this patient population is at very high CVD risk, SGLT2 inhibitors should be prescribed where appropriate to allow patients to receive cardiovascular and renal benefits. 1. Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives). No. 2. Would implementation of any of the draft recommendations have significant cost	

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				implications? Prescription costs may increase due to more patients being prescribed SGLT2 inhibitors, though this would be expected to reduce later costs due to CVD etc, as more people will be receiving organ protective therapies which they are currently being denied. 3. Should NICE update the existing technology appraisals for canagliflozin, dapagliflozin, empagliflozin, and ertugliflozin (TA288, TA315, TA336, TA390, TA418, TA572, TA583)? If so, please provide a rationale for this. Details of the update process are in NICE health technology evaluations: the manual, see 8.4 Surveillance decision options. Potentially should be updated regarding prescription of these meds in those with type 2 diabetes and DFD	

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					The Whole Lifecycle Approach workstream is determining the best approach to updating technology appraisals as a result of the changes in this guideline update. NICE will consult on a

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					review proposal regarding the update of the relevant SGLT2 inhibitor technology appraisals.
University of Oxford	Guideline	General		The diagram of treatment options only mentions dietary advice at the top of the previous page. This risks this information being overlooked during busy clinics. We propose that both dietary advice and referral to Path to Remission should feature within the diagram alongside further treatment options.	Thank you for your comment. The treatment summary diagram is meant to explain the medicines update of the guideline. Given the limited space and to reduce the overload to people using the summary, while we agree this is important, there are no plans to add information about sections of the guideline that were not updated in this review at this time.
University of Oxford	Guideline	007-008	027-028 001-002	1.7.8 Here, the guidance should go beyond reinforcing the advice about diet and healthy living to referral to relevant services (e.g., weight management services) in line with the NICE guidance on obesity and NICE guidance on behaviour change, as offering support improves dietary adherence and control of HbA1c more than offering advice alone.	Thank you for your comment. This is out of scope for the guideline update. However, we have made an additional recommendation at the start of the medicines section to highlight the importance of discussing dietary advice and healthy living.
University of Oxford	Guideline	006	027-029	1.3.1 Most healthcare professionals who interact with people with diabetes do not have specific expertise and competencies in nutrition, but this does not mean that their intervention on this subject is any less important. Additionally, research evidence supports that people with type 2 diabetes do want their primary healthcare providers to support them with	Thank you for your comment. This is out of scope for the guideline update. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.

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				advice about what they should eat and how to lose weight. Providing nutritional advice only by healthcare professionals with specific expertise and competencies will significantly increase costs and reduce equitable access. Instead, healthcare professionals should: - follow the core principles of behaviour change as specified in the NICE guidance on behaviour change (PH49) when providing advice - refer people with diabetes to relevant services, as people are more likely to make	
University of Oxford	Guideline	007	004-010	1.3.3 We welcome the recommendation that people with type 2 diabetes should follow the same healthy eating advice as the general population. However, the specific points mentioned in the guidance do not fully align with the Eatwell guide, the UK's official dietary advice. We note that this point was from the 2009 guidance and the updated Eatwell guide was published in 2016. We recommend the dietary advice is updated accordingly. In particular:	Thank you for your comment. This is out of scope for the guideline update. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.

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				- There is no mention of low-glycaemic index sources of carbohydrates in the EatWell guide There is no mention of “controlling saturated and trans fat”, but rather (a) limiting saturated fat, (b) avoiding trans fat, and (c) choosing unsaturated oils in small amounts. - The Eatwell guide also specifically recommends eating foods high in fat, salt, and sugar less often and in small amounts. This is particularly important for most people with type 2 diabetes as they are also living with overweight or obesity.	
University of Oxford	Guideline	007	011-014	1.3.4 The committee should consider significantly strengthening this point. They should specify that all people recently diagnosed with type 2 diabetes who are eligible for NHS T2D Path to Remission programme should be referred to it at the earliest opportunity. Evidence from clinical trials and the evaluation of the nationally available NHS T2D Path to Remission programme shows that most people who are agree to take part, attend most of the programme, lose a significant amount of weight (an average of 8.3%), and about a third (27-45%) achieve type 2 diabetes remission.	Thank you for your comment. The dietary advice section of the type 2 diabetes guideline (NG28) was out of scope for this medicines update. However, we have added a recommendation in the ‘Involving people in medicine discussions’ section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A cross-reference link has been added to the NHS Pathways to Remission programme which can be used to access eligibility and referral thresholds.

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				We strongly suggest that ways to achieve T2D remission should more prominently feature in the NICE guidance, as achieving remission is the top priority for patients, healthcare professionals, and policy makers, and its omission risks signalling to practitioners that this is not a priority nor feasible goal for people living with T2D – when there is clear and compelling evidence to the contrary. Our recent NIHR and Diabetes UK funded research on supporting professionals to talk about remission with people with T2D developed this infographic which we hope will be of use in these consultations: (pre-print link ahead of publication): https://www.researchgate.net/publication/389128495_Communicating_diabetes_remission_and_referrals and would be happy to share the manuscript and copy of the infographic ahead of publication.	A cross reference has also been added to recommendations on low-energy and very-low-energy diets to achieve type 2 diabetes remission which was considered as part of the update of the overweight and obesity management guideline (NG 246). Thank you for bringing the findings of the recent NIHR and Diabetes UK funded research to our attention.
University of Oxford	Guideline	007	011-014	1.3.7 This point is inconsistent with the Eatwell guide, which offers no advice to individualise carbohydrate or alcohol intake recommendations. There is also no evidence that such individualised recommendations promote diabetes control. If this	Thank you for your comment. The dietary advice section of the type 2 diabetes guideline (NG28) was out of scope for this medicines update. However, We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and

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				point is directed at people using insulin or an insulin secretagogue, this should be made clear to avoid any suggestion that this might apply to everyone with type 2 diabetes. Practitioners and patients express specific needs for advice in relation to carbohydrate intake. The SACN review of reviews concluded that low-carbohydrate diets demonstrated short-term benefits for glycaemic control and triglyceride levels in adults with type 2 diabetes and overweight or obesity. A more recent systematic review supported low carbohydrate diets as an option for people with type 2 diabetes: https://pubmed.ncbi.nlm.nih.gov/33441384/ In addition, we have recently completed an HTA-funded randomised controlled trial (n=626) where we provided people with type 2 diabetes with support to follow a low-carbohydrate diet in primary care and assessed their chances of T2D diabetes remission. We are happy to share the results in confidence ahead of publication.	continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. The role of low carbohydrate diets was considered in the updated overweight and obesity management guideline (NG246). The guideline committee were keen that the review examined the long-term effectiveness of different diets (including low carbohydrate diets). Therefore, the review protocol outlined that interventions with a minimum follow-up of 12 months should be included. The review included four RCTs looking at low carbohydrate diets in people with type 2 diabetes and four RCTs looking at very low carbohydrate diets in people with type 2 diabetes. The findings showed that it could not differentiate between the interventions (low carbohydrate or very low carbohydrate diets vs usual care/ support) in key outcomes such as weight at one year, % change in HbA1c, waist circumference and Quality of Life. Based on the evidence and their expertise, the committee amended an existing recommendation stating that dietary approaches to support weight loss should maintain an energy deficit and this can be achieved by lowering specific macronutrient content (recommendation 1.16.3 in NG246).

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					The highlighted Goldenberg et al (2021) systematic review was considered in evidence review F (effectiveness of different diets for achieving and maintaining weight loss) for the overweight and obesity management guideline. It was excluded due to including an analysis of a very low-calorie ketogenic diet and low-calorie diet together contrary to the review inclusion criteria. Thank you for information about your study. This is outside of the scope for this guideline update and so cannot be included in this update.
University of Oxford	Guideline	007	023-026	1.3.8 This point is also inconsistent with the Eatwell guide. There is no mention in the guide about substitution of a limited amount of sucrose-containing foods for other carbohydrate. Instead, the guide is explicit that people should “cut down on sugar” with no more than 5% of the energy consumed coming from free sugars. As above, the guide recommends eating foods high in fat, salt, and sugar less often and in small amounts. We suggest this is reworded in line with the Eatwell guide. In relation to points 1.3.3, 1.3.7, and 1.3.8, we also refer the Committee to the Scientific Advisory	Thank you for your comment. This is out of scope for the guideline update. However, we have added a recommendation in the ‘Involving people in medicine discussions’ section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline.

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				Committee on Nutrition (SACN) Carbohydrate and Health report: https://www.gov.uk/government/publications/sacn-carbohydrates-and-health-report	
University of Oxford	Guideline	07	011-014	1.3.6 Losing weight is the most important predictor of type 2 diabetes remission among people who are living with overweight and obesity. People consistently lose more weight when provided with structured support rather than advice alone. Therefore, this point should be extended beyond advice to specifically recommend offering support by referral to structured weight management programmes, in accordance with the NICE guidance on overweight and obesity management (NG246).	Thank you for your comment. This section is out of scope for the guideline update. We have added a new recommendation into the section about Involving people in medicine discussions to state that dietary advice and other aspects of healthy living such as physical activity should be used alongside medicines and have referred to the NHS Type 2 diabetes Path to Remission Programme, the NICE guideline on overweight and obesity management and the NHS Better Health website.
University of Oxford	Guideline	010	016-018	Overall, we are concerned that the guidance does not recognise dietary weight loss as the cornerstone and first-line treatment for T2D diabetes. We recommend that the guidance should emphasise that medication should only be introduced if dietary change and weight control are insufficient to achieve glycaemic control and/or remission.	Thank you for your comment. We agree that dietary weight loss is an important part of supporting people with type 2 diabetes. The guideline includes recommendations on dietary advice significantly earlier than medicines. Additionally, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to

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					Remission Programme and links to the overweight and obesity management guideline. We believe that the guideline as a whole emphasises that healthy living and diet is the first line management option and that medicines is the next step for some people. However, this update is focussed on medicines and so reduces the focus on this area for this consultation, which we appreciate.
X-PERT Health	Guideline	General		The updates to the individualised care (1.1) and dietary advice sections (1.3) do not address concerns that we had previously expressed in conjunction with the British Dietetic Association (BDA) and the Public Health Collaboration. These concerns were set out in an open letter that can be accessed at https://www.xperthealth.org.uk/wp-content/uploads/2025/03/Letter-to-NICE-re-NG28-FINAL.pdf. The response to this letter (on behalf of NICE) intimated that amendments would be made as part of the current update to address these concerns. However, the updated guidance still fails to: 1. make it clear that remission of type 2 diabetes is a realistic goal for many, 2. support a range of dietary approaches,	Thank you for your comment. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. The dietary advice section of the guideline recommends to provide individualised and ongoing nutritional advice. The guideline also cross-references to NICE's guideline on shared decision making, which covers how to make shared decision making part of everyday care in all healthcare settings and promotes ways for healthcare professionals and people using services to work together to make decisions about treatment and care.

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				3. support shared decision making through the promotion of individualised and flexible approaches, which would help patients to adopt a way of eating that meets their needs and preferences. The lack of meaningful changes to relevant recommendations also means that the dietary advice within NG28 is still inconsistent with that of most other notable national and international guidelines for people with type 2 diabetes (including those provided by Diabetes UK, the BDA, the Scottish Intercollegiate Guidelines Network, the American Diabetes Association, the European Association for the Study of Diabetes, and Diabetes Australia). It is also inconsistent with the dietary advice in the recently updated NICE guidelines on overweight and obesity management (NG246). The inconsistency between these guidelines risks causing confusing amongst healthcare professionals and people with type 2 diabetes, particularly the conflicting advice between different NICE guidelines (i.e., NG28 and NG246) that would both be relevant for many people with type 2 diabetes. These issues can still be addressed as part of the current update, by:	A cross reference has been added to recommendations on low-energy and very-low-energy diets for the management of type 2 diabetes which was considered as part of the update of the overweight and obesity management guideline (NG 246). Regarding the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes. This review included interventions with a minimum of 3 months duration. This review considered short term interventions and the evidence suggested beneficial effects on HbA1c, fasting plasma glucose and serum triacylglycerol in the shorter term (up to 6 months). However, no differences were observed in the longer term ($\geq$ 12 months). The role of low carbohydrate diets was considered in the updated overweight and obesity management guideline (NG246). The guideline committee were keen that the review examined the long-term effectiveness of different diets (including low carbohydrate diets). Therefore, the review

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				- using relevant recommendations from NG246 (particularly 1.16.1 and 1.16.3, which promote flexible and individualised approaches and support the use of a range of dietary approaches) in place of the corresponding recommendations from NG28 (particularly 1.3.3, which continues to promote a single approach which does not support patient choice or allow meaningful flexibility), - adding recommendations that promote the remission of type 2 diabetes as a suitable treatment target for many, and that provide guidance on how to support people to try and achieve this. Although the original scope of this update was limited to medicines, we believe the comments presented here should be given full consideration due to the following facts: - There are amendments to relevant recommendations in the draft guidelines (e.g., recommendations 1.1.4, 1.3.4 and 1.3.11). Our comments should therefore be	protocol outlined that interventions with a minimum follow-up of 12 months should be included. The review included four RCTs looking at low carbohydrate diets in people with type 2 diabetes and four RCTs looking at very low carbohydrate diets in people with type 2 diabetes. The findings showed that it could not differentiate between the interventions (low carbohydrate or very low carbohydrate diets vs usual care/ support) in key outcomes such as weight at one year, % change in HbA1c, waist circumference and Quality of Life. Based on the evidence and their expertise, the committee amended an existing recommendation stating that dietary approaches to support weight loss should maintain an energy deficit and this can be achieved by lowering specific macronutrient content (recommendation 1.16.3 in NG246).

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				considered to be in scope due to their relevance to these updates. 2. The response to the aforementioned open letter intimated that changes would be considered as part of this update to address our concerns. Comments related to these concerns should therefore also be considered in scope. Further, as the evidence review used in the development of NG246 included studies in people with type 2 diabetes, and was carried out much more recently than the last review of evidence to inform possible updates to the dietary advice in NG28*, we feel it is justifiable to use this to inform amendments as part of the current update without the need for a separate review of evidence to be carried out. The outcomes of the review on the use of low(er) carbohydrate dietary approaches in people with type 2 diabetes carried out by the joint working group of the Scientific Advisory Committee on Nutrition (SACN), NHS England and Diabetes UK also support the amendments suggested above**.	

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				* The dietary advice section of NG28 has not been updated since 2009. The evidence review used to inform the 2009 update was carried out in 2007. ** This review found no evidence of safety concerns linked to the use of low(er) carbohydrate dietary approaches. It also demonstrated that low(er) carbohydrate approaches were non-inferior (at least) to the dietary advice given in the existing guidelines in relation to all of the assessed health markers and clinical outcomes. These findings therefore support the expansion of the dietary advice in NG28 to include multiple dietary approaches as suitable options for people with type 2 diabetes.	
X-PERT Health	Guideline	005	004	Rec 1.1.4 – We are concerned that this recommendation may increase confusion amongst healthcare professionals, and amongst people with type 2 diabetes, due to the fact the dietary advice in the NICE guideline on overweight and obesity management which is being referred to (NG246) is contradictory to the dietary advice within the current guideline (NG28). NG246 promotes flexible and individualised dietary approaches, and a range of different eating patterns. NG28 does not. We are particularly concerned as to how these conflicting guidelines may affect the care of people with type 2 diabetes who also have overweight or obesity, for	Thank you for your comment. This draft guideline consultation was to update the Type 2 Diabetes guideline for medicines. Therefore, the dietary advice section of the type 2 diabetes guideline (NG28) was out of scope. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission

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				whom both NG246 and NG28 can be considered relevant. As the dietary advice in NG28 is outdated*, and inconsistent with most other notable national and international guidelines for people with type 2 diabetes (including those provided by Diabetes UK, the BDA, the Scottish Intercollegiate Guidelines Network, the American Diabetes Association, the European Association for the Study of Diabetes, and Diabetes Australia), we believe that the most appropriate way to address this issue would be to use relevant recommendations from NG246 (particularly 1.16.1 and 1.16.3, which promote flexible and individualised approaches and support the use of a range of dietary approaches) to replace the corresponding recommendations from NG28 (particularly 1.3.3, which continues to promote a single approach which does not support patient choice or allow meaningful flexibility). As the evidence review used in the development of NG246 included studies in people with type 2 diabetes, and was carried out much more recently than the last review of evidence to inform possible updates to the dietary advice in NG28, we feel it is justifiable to use this to inform amendments as part of the current update without the need for a	Programme and links to the overweight and obesity management guideline. A cross reference has been added to recommendations on low-energy and very-low-energy diets for the management of type 2 diabetes which was considered as part of the update of the overweight and obesity management guideline (NG 246). Regarding the 2021 SACN review of lower carbohydrate diets for adults with type 2 diabetes. This review included interventions with a minimum of 3 months duration. This review considered short term interventions and the evidence suggested beneficial effects on HbA1c, fasting plasma glucose and serum triacylglycerol in the shorter term (up to 6 months). However, no differences were observed in the longer term (≥ 12 months). The role of low carbohydrate diets was considered in the updated overweight and obesity management guideline (NG246). The guideline committee were keen that the review examined the long-term effectiveness of different diets (including low carbohydrate diets). Therefore, the review

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				separate review of evidence to be carried out. The outcomes of the review on the use of low(er) carbohydrate dietary approaches in people with type 2 diabetes carried out by the joint working group of the Scientific Advisory Committee on Nutrition (SACN), NHS England and Diabetes UK also support the amendments suggested above**. * The dietary advice section of NG28 has not been updated since 2009. The evidence review used to inform the 2009 update was carried out in 2007. ** This review found no evidence of safety concerns linked to the use of low(er) carbohydrate dietary approaches. It also demonstrated that low(er) carbohydrate approaches were non-inferior (at least) to the dietary advice given in the existing guidelines in relation to all of the assessed health markers and clinical outcomes. These findings therefore support the expansion of the dietary advice in NG28 to include multiple dietary approaches as suitable options for people with type 2 diabetes.	protocol outlined that interventions with a minimum follow-up of 12 months should be included. The review included four RCTs looking at low carbohydrate diets in people with type 2 diabetes and four RCTs looking at very low carbohydrate diets in people with type 2 diabetes. The findings showed that it could not differentiate between the interventions (low carbohydrate or very low carbohydrate diets vs usual care/ support) in key outcomes such as weight at one year, % change in HbA1c, waist circumference and Quality of Life. Based on the evidence and their expertise, the committee amended an existing recommendation stating that dietary approaches to support weight loss should maintain an energy deficit and this can be achieved by lowering specific macronutrient content (recommendation 1.16.3 in NG246).
X-PERT Health	Guideline	007	011	Rec 1.3.4 - We believe that the reference to the NHS Type 2 diabetes Path to Remission Programme would be more effective if recommendations that highlight remission as a realistic treatment aim for many people with type 2	Thank you for your comment. We have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and

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X-PERT Health	Guideline	008	009	Rec 1.3.11 – We are concerned that this recommendation may increase confusion amongst healthcare professionals, and amongst people with type 2 diabetes, due to the fact the dietary advice in the NICE guideline on overweight and obesity management which is being referred to (NG246) is contradictory to the dietary advice within the current guideline (NG28). NG246 promotes flexible and individualised dietary approaches, and a range of different eating patterns. NG28 does not. We are particularly concerned as to how these conflicting guidelines may affect the care of people with type 2 diabetes who also have overweight or obesity, for whom both NG246 and NG28 can be considered relevant.	Thank you for your comment. This draft guideline consultation was to update the Type 2 Diabetes guideline for medicines. Therefore the dietary advice section of the type 2 diabetes guideline (NG28) was out of scope. However, we have added a recommendation in the 'Involving people in medicine discussions' section that highlights the need to discuss healthy living advice when considering medicines and continuing the personalised diabetes management plan. This includes guidance on the NHS Type 2 Diabetes Path to Remission Programme and links to the overweight and obesity management guideline. A cross reference has been added to recommendations on low-energy and very-low-energy diets for the management of

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**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*

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