Consultation on draft guideline – deadline for comments 5pm on 2 October 2025 **email: t2diabetesadults@nice.org.uk**

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- **Do not submit further attachments** such as research articles, or supplementary files. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. You are welcome to include links to research articles or provide references to them
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 comments form from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public with underlining and highlighting. Also, ensure you state in your email to NICE, and in the row below, that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- **We have not reviewed the evidence for the recommendations shaded in grey. Therefore, please do not submit comments relating to these recommendations as we cannot accept comments on them.**
- **We do not accept comments submitted after the deadline stated for close of consultation.**

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate. Where comments contain confidential information, we will redact the relevant text, or may redact the entire comment as appropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 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. 2. Would implementation of any of the draft recommendations have significant cost implications? 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. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	Royal College of General Practitioners
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	**None**
Confidential comments (Do any of your comments contain confidential information?)	No
Name of person completing form	Michael Mulholland and Adrian Hayter

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Comment number	**Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA]	**Page number** **'General'** for comments on whole document	**Line number** **'General'** for comments on whole document	**Comments** • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
Example	Guideline	016	045	Rec 1.3.4 – We are concerned that this recommendation may imply that ……..
Example	Guideline	017	023	Question 1: This recommendation will be a challenging change in practice because ……
Example	Guideline	037	016	This rationale states that…
Example	Evidence review C	057	032	There is evidence that …
Example	Evidence review C	063	012	CONFIDENTIAL: Our unpublished study has shown that [X] is more effective than [Y]
Example	Methods	034	010	The inclusion criteria …
Example	Algorithm	General	General	The algorithm seems to imply that …
Example	EIA	010	002	We agree with the barriers to access listed, and would also like to add ….
1	Guideline	General	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.
2	Guideline	12-14	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. 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.

3	Guideline	18	013	We believe that recommending metformin plus SGLT-2 inhibitor as first-line therapy represents a major shift. This raises questions about: o Patient acceptability: starting dual therapy immediately after diagnosis may feel burdensome. o Affordability and local prescribing (primary care budgets are already under strain).
4	Guideline	19	015	We are concerned that the inclusion of subcutaneous semaglutide alongside SGLT-2 inhibitors for people with ASCVD has practical issues for primary care: o Limited primary care experience initiating GLP-1 therapy (usually specialist-led) o Patient acceptability: starting triple therapy immediately after diagnosis may feel very burdensome o Costs and formulary approval
5	Guideline	22	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.
6	Guideline	General	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 ie 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 decision making creates a more personalised approach.

7	Guideline	General	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.
				• 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.
				• 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.
8	Visual flowchart	General	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.

Insert extra rows as needed

Data protection
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By submitting your data via this form you are confirming that you have read and understood this statement.

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