UK National Screening Committee

Consultation Comments Pro-forma

Population screening for Type 2 diabetes evidence map

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Section and / or page number	**Text or issue to which comments relate**	**Comment** *Please use a new row for each comment and add extra rows as required.*
		The consultation concludes that there is insufficient randomised controlled trial evidence to support population-wide screening for type 2 diabetes within the NHS. However, in practice, the NHS already delivers targeted screening through the NHS Health Check programme for adults aged 40–74 without pre-existing conditions. In that context, the more pertinent question may be whether there is evidence of cost-effectiveness for an additional screening programme aimed at adults under 40 without pre-existing conditions. **We suggest that consultations of this nature should not rely solely on limited RCT evidence, but also consider feasibility, acceptability, and the current landscape and workload pressures within primary care. Prevalence data in younger age groups, particularly in areas of higher deprivation, should also inform further scoping work.** **Excluding adults under 40 from consideration for screening may disproportionately disadvantage more deprived populations, who often experience obesity and metabolic disease at younger ages. Evaluation of targeted screening approaches in younger individuals with raised BMI or other defined risk factors would be a constructive area for future**

		review. **We believe there is a clear need for more consistent targeted screening of high-risk groups, including people from diverse ethnic backgrounds, women with a history of gestational diabetes, and those with elevated BMI. In practice, this should largely be delivered through the NHS Health Check programme.**
		We note that patients with a learning disability experience prediabetes and type 2 diabetes at a younger age and often have significant additional risk factors. Similarly, people living with severe mental illness are known to have increased cardiometabolic risk. **In this context, a population health approach that targets defined "at risk" cohorts may be more appropriate than universal screening. Consideration could be given to incorporating structured diabetes case-finding within existing frameworks, such as the annual health check for people with a learning disability and the severe mental illness (SMI) health check. This would allow earlier identification in higher-risk groups using established review mechanisms, rather than introducing a separate population-wide screening programme.**
		We recognise that current evidence has not consistently demonstrated that universal population screening for type 2 diabetes results in significant reductions in all-cause mortality or major cardiovascular outcomes when compared with usual care. Large trials suggest that earlier diagnosis through screening does not automatically translate into measurable long-term benefit at a population level.
		Screening may identify individuals with mild or slowly progressive hyperglycaemia who may never go on to develop complications. This raises concerns about unnecessary diagnostic labelling, increased anxiety, greater healthcare utilisation, and potential exposure to pharmacological treatment without clear evidence of benefit.
		A national screening programme would require substantial NHS resource. In the absence of strong evidence of benefit,

		there is a risk that capacity could be diverted from established interventions, such as cardiovascular risk management, weight management services, and targeted prevention programmes. **Primary care already undertakes opportunistic case-finding in high-risk individuals, supported by chronic disease reviews and the NHS Health Check programme. This existing activity may reduce the additional benefit derived from introducing a formal universal screening programme.**
		There is strong evidence that identifying individuals with non-diabetic hyperglycaemia and offering structured lifestyle interventions can reduce progression to diabetes. Screening approaches may therefore confer indirect benefit by identifying those most likely to benefit from preventative interventions.
		There remains uncertainty regarding the most appropriate screening modality, including the relative role of HbA1c, fasting plasma glucose, and validated risk scores, as well as the optimal diagnostic thresholds and screening intervals. In addition, variability in test performance across different age groups, ethnic backgrounds, and comorbidity profiles limits confidence in the suitability of a single national screening programme.

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