NICE National Institute for Health and Care Excellence

Single Technology Appraisal

Semaglutide for preventing major cardiovascular events in people with cardiovascular disease and overweight or obesity [ID6441]

Professional organisation submission

Thank you for agreeing to give us your organisation's views on this technology and its possible use in the NHS.

You can provide a unique perspective on the technology in the context of current clinical practice that is not typically available from the published literature.

To help you give your views, please use this questionnaire. You do not have to answer every question – they are prompts to guide you. The text boxes will expand as you type.

Information on completing this submission

- Please do not embed documents (such as a PDF) in a submission because this may lead to the information being mislaid or make the submission unreadable
- We are committed to meeting the requirements of copyright legislation. If you intend to include **journal articles** in your submission you must have copyright clearance for these articles. We can accept journal articles in NICE Docs.
- Your response should not be longer than 13 pages.

NICE National Institute for Health and Care Excellence

About you

1. Your name	**Michael Mulholland/Adrian Hayter**
2. Name of organisation	**Royal College of General Practitioners**
3. Job title or position	**Honorary Secretary/ Medical Director, Clinical Policy**
4. Are you (please select Yes or No):	An employee or representative of a healthcare professional organisation that represents clinicians? Yes A specialist in the treatment of people with this condition? No A specialist in the clinical evidence base for this condition or technology? No
5a. Brief description of the organisation (including who funds it).	The Royal College of General Practitioners (RCGP) is the UK's professional membership body for general practitioners. The College is committed to improving patient care, clinical standards, and GP training. It is a registered charity, primarily funded by membership fees, grants, educational activities, and professional events.
5b. Has the organisation received any funding from the manufacturer(s) of the technology and/or comparator products in the last 12 months? [Relevant manufacturers are listed in the appraisal matrix.] **If so, please state the name of manufacturer, amount, and purpose of funding.**	No
5c. Do you have any direct or indirect links with, or funding from, the tobacco industry?	No

The aim of treatment for this condition

6. What is the main aim of treatment? (For example, to stop progression, to improve mobility, to cure the condition, or prevent progression or disability.)	The main aim of treatment is to reduce the risk of major adverse cardiovascular events (MACE) in individuals with established CVD who also live with overweight or obesity. This includes reducing the likelihood of events such as MI, stroke, and CV death, while also improving overall metabolic health and supporting sustained weight loss.
7. What do you consider a clinically significant treatment response? (For example, a reduction in tumour size by x cm, or a reduction in disease activity by a certain amount.)	A clinically significant response would be a meaningful reduction in cardiovascular events (e.g., >20% relative risk reduction in MACE), accompanied by sustained weight loss of at least 5–10% of baseline body weight, improvements in blood pressure, glycaemic control, and lipid profile. In primary care, improvements in functional capacity and quality of life - particularly where obesity contributes to multimorbidity - are also key markers of success.
8. In your view, is there an unmet need for patients and healthcare professionals in this condition?	Yes. Despite the well-established link between obesity and CVD, there are few effective and sustainable treatment options available in primary care. Lifestyle interventions are important but often insufficient on their own for those at high CV risk. There is also limited access to multidisciplinary weight management services. Semaglutide offers a potential option to fill this treatment gap by addressing both weight and CV risk through a pharmacological approach.

What is the expected place of the technology in current practice?

9. How is the condition currently treated in the NHS?	Patients with CVD and obesity are typically managed with a combination of lifestyle advice, pharmacotherapy for cardiovascular risk factors (e.g. antihypertensives, statins), and support for weight management. In primary care, GPs provide brief interventions and may refer patients to tier 2 or 3 weight management services, which vary significantly by region and often oversubscribed.
9a. Are any clinical guidelines used in the treatment of the condition, and if so, which?	Yes. NICE guidelines on obesity (CG189), cardiovascular disease prevention (CG181), and the newer guidelines for pharmacological interventions in obesity (NG224) are commonly referenced. Additionally, SIGN, ESC, and EASO guidelines are sometimes used in more specialist settings.
9b. Is the pathway of care well defined? Does it vary or are there differences of opinion between professionals across the NHS? (Please state if your experience is from outside England.)	There is variability across NHS. While pathways are theoretically tiered (tiers 1-4), in practice, access to higher-tier weight management services is limited and often inequitable. There is variation in referral thresholds, availability, and regional commissioning policies, which can create disparities in care.
9c. What impact would the technology have on the current pathway of care?	Semaglutide could provide an effective pharmacological option in primary care settings for people with established CVD and obesity. It may reduce the need for referrals to higher-tier services or complement these services when combined with lifestyle and behavioural interventions. It could also shift the management of obesity from being seen as predominantly lifestyle-based to a more medicalised, long-term risk-reduction strategy.

10. Will the technology be used (or is it already used) in the same way as current care in NHS clinical practice?	Semaglutide is already used in NHS settings for type 2 diabetes and weight management (under different criteria). However, for cardiovascular prevention in patients with obesity, this represents a novel indication. Its use will align partially with existing care but would expand pharmacological options available in primary care to address both obesity and cardiovascular risk.
10a. How does healthcare resource use differ between the technology and current care?	Current care relies heavily on lifestyle advice and long-term management of comorbidities such as hypertension, hyperlipidaemia, and diabetes. Introducing semaglutide may increase short-term prescribing costs and require initial training and monitoring. However, it may reduce long-term healthcare utilisation by preventing cardiovascular events, delaying complications, and reducing medication burden across multiple domains (e.g., antihypertensives, insulin, statins).
10b. In what clinical setting should the technology be used? (For example, primary or secondary care, specialist clinics.)	The technology could be used in primary care, especially for patients already under GP care for cardiovascular disease. It may also be used in specialist weight management or cardiometabolic clinics for complex cases or for initiation and titration before shared care agreements in general practice.
10c. What investment is needed to introduce the technology? (For example, for facilities, equipment, or training.)	Training for primary care clinicians and pharmacists on prescribing, eligibility, and monitoring • Clear clinical protocols and inclusion criteria • Digital or manual systems to support follow-up and outcome tracking • Patient education resources

	Infrastructure costs are likely modest, as semaglutide is already used in other indications.
11. Do you expect the technology to provide clinically meaningful benefits compared with current care?	Yes. Semaglutide has the potential to reduce cardiovascular events and improve weight-related comorbidities, which current care often fails to achieve sustainably through lifestyle interventions alone.
11a. Do you expect the technology to increase length of life more than current care?	Yes. Particularly in individuals with established CVD. Evidence suggests that reducing cardiovascular events through GLP-1 receptor agonists can lead to increased survival.
11b. Do you expect the technology to increase health-related quality of life more than current care?	Yes. Improvements in weight, blood pressure, glycaemic control, and physical function can lead to better mobility, lower medication burden, and improved mental health -all of which enhance quality of life.
12. Are there any groups of people for whom the technology would be more or less effective (or appropriate) than the general population?	The technology is likely most effective in people with established CVD and class II or III obesity. It may be less appropriate in individuals with a history of pancreatitis, severe gastrointestinal conditions, or those with contraindications to GLP-1 receptor agonists. Adherence may also be lower in populations with needle phobia unless oral formulations become available

The use of the technology

13. Will the technology be easier or more difficult to use for patients or healthcare professionals than current care? Are there any practical implications for its use (for example, any concomitant treatments needed, additional clinical requirements, factors affecting patient acceptability or ease of use or additional tests or monitoring needed.)	Semaglutide is generally well tolerated and easy to administer once weekly via subcutaneous injection. While this may be a barrier for some patients (e.g., those with needle phobia), many find the once-weekly dosing acceptable and preferable to daily medications. There is a need for initial counselling and training on administration. Monitoring for gastrointestinal side effects and weight loss progress is needed, but this can be integrated into routine reviews in primary care or supported remotely. No significant concomitant treatments are required beyond standard cardiovascular risk management.
14. Will any rules (informal or formal) be used to start or stop treatment with the technology? Do these include any additional testing?	Yes. It is likely that clear eligibility criteria will be required (e.g. established CVD and a specific BMI threshold). Formal stopping rules- such as achieving a minimum percentage weight loss by a defined time point (e.g. 5% by 6 months)- may be necessary to ensure clinical and cost-effectiveness. Periodic weight and cardiovascular risk monitoring would be standard practice.

15. Do you consider that the use of the technology will result in any substantial health-related benefits that are unlikely to be included in the quality-adjusted life year (QALY) calculation?	Yes. Improvements in self-esteem, physical functioning, ability to work or care for family, and reductions in weight-related stigma are important and may not be fully captured in QALY modelling. Reduced polypharmacy and medication burden can also enhance wellbeing.
16. Do you consider the technology to be innovative in its potential to make a significant and substantial impact on health-related benefits and how might it improve the way that current need is met?	Yes. Semaglutide represents a step-change in managing obesity not just as a lifestyle issue but as a treatable chronic disease with cardiometabolic consequences. It provides GPs with an evidence-based pharmacological tool that addresses both obesity and cardiovascular risk, potentially shifting the clinical paradigm.
16a. Is the technology a 'step-change' in the management of the condition?	Yes. It redefines obesity and cardiovascular risk management in primary care and offers a new treatment avenue for patients previously limited to lifestyle advice and non-specific support.
16b. Does the use of the technology address any	Yes.

particular unmet need of the patient population?	It provides an evidence-based treatment option for people with obesity and CVD who often have limited or no access to structured tier 3 services or face long waits for specialist care.
17. How do any side effects or adverse effects of the technology affect the management of the condition and the patient's quality of life?	The most common adverse effects (nausea, vomiting, diarrhoea) are usually transient and manageable. They may require dose titration and patient support but rarely lead to discontinuation. Long-term tolerability is generally good, and these side effects are outweighed by the potential benefits in appropriate patients.

Sources of evidence

18. Do the clinical trials on the technology reflect current UK clinical practice?	Broadly, yes. Trials such as SELECT included patients with established cardiovascular disease and BMI thresholds relevant to UK populations. However, real-world implementation will involve a more diverse range of patients and healthcare settings.
18a. If not, how could the results be extrapolated to the UK setting?	Results can be extrapolated with minor caution, taking into account the UK's primary care-led management of chronic disease and variability in access to weight management services.

18b. What, in your view, are the most important outcomes, and were they measured in the trials?	Yes. Key outcomes such as cardiovascular event rates, weight loss, and quality-of-life measures were included. Additional functional and psychological outcomes could enhance future evaluations.
18c. If surrogate outcome measures were used, do they adequately predict long-term clinical outcomes?	Yes. Cardiovascular event reduction and sustained weight loss are strong predictors of long-term health benefits.
18d. Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently?	No major unexpected adverse events have been identified in routine use to date, though ongoing pharmacovigilance is important, especially regarding rare events such as pancreatitis.
19. Are you aware of any relevant evidence that might not be found by a systematic review of the trial evidence?	Real-world data from NHS specialist weight management services and anecdotal reports from GPs using semaglutide for other indications suggest high acceptability and notable improvements in multimorbidity, but these are not yet fully published.
20. How do data on real-world experience	Real-world data generally align with trial outcomes in terms of weight loss and tolerability. Adherence rates may be slightly lower, and patient selection is broader, but overall effectiveness remains strong in motivated patients.

compare with the trial data?	

Equality

21a. Are there any potential equality issues that should be taken into account when considering this treatment?	Yes. People from deprived backgrounds and ethnic minority groups are disproportionately affected by obesity and CVD but may face greater barriers to access new treatments. Ensuring equity in prescribing and education will be important. People with learning difficulties, severe mental illness, or language barriers may also need tailored support.
21b. Consider whether these issues are different from issues with current care and why.	Current care often already fails to meet the needs of these populations due to inconsistent access to tiered services and under-resourcing of primary care. If not carefully implemented, new technologies like semaglutide may exacerbate inequalities unless clear equity-focused commissioning is applied.

Key messages

22. In up to 5 bullet points, please summarise the key messages of your submission.	• There is a significant unmet need in primary care for effective treatment options for patients with obesity and established cardiovascular disease. • Semaglutide offers a clinically effective pharmacological approach that reduces cardiovascular events and supports weight loss, addressing both conditions simultaneously. • Its use in primary care could shift the paradigm from reactive to proactive cardiometabolic risk management. • While implementation requires investment in training and systems, it has the potential to reduce long-term healthcare costs and improve patient outcomes. • Equity in access and prescribing will be essential to avoid widening existing health inequalities

Thank you for your time.

Please log in to your NICE Docs account to upload your completed submission.

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Additional Submission Responses

9. How is the condition currently treated in the NHS?

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10. Will the technology be used (or is it already used) in the same way as current care in NHS clinical practice?

Content to be inserted...

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18. Do the clinical trials on the technology reflect current UK clinical practice?

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19. Are you aware of any relevant evidence that might not be found by a systematic review of the trial evidence?

Content to be inserted...

20. How do data on real-world experience compare with the trial data?

Content to be inserted...

21a. Are there any potential equality issues...

Content to be inserted...

22. In up to 5 bullet points, please summarise the key messages of your submission.

Content to be inserted...