Implementing the 2026 NICE NG28 Updates:

The "cardiorenal-metabolic protection" model.

- No longer automatically starting everyone on Metformin alone as first line

<u>Oral Medications & SGLT2i First-Line, The "Standard" Pathway (No Major Comorbidities)</u>

- **Default Initial Treatment:** Offer dual therapy from day one with **Modified-Release (M/R) Metformin + an SGLT2 inhibitor**.
- **Why M/R Metformin?** NICE now preferentially recommends the M/R formulation over standard-release for initial treatment due to a significantly lower risk of GI side effects and better long-term compliance.

The Comorbidity Pathway (Heart Failure, ASCVD, or CKD)

1st Line Immediate Dual Therapy:

Start M/R Metformin + SGLT2i immediately, **regardless of baseline HbA1c**.

The "No-Stop" Rule:

If an SGLT2i is started for cardiorenal protection, **do not stop it** if the patient fails to meet glycemic targets. It is there to protect the organs, not just lower glucose.

GLP-1 RAs & Tirzepatide

Immediate Triple Therapy for ASCVD

- For patients with established **atherosclerotic cardiovascular disease (ASCVD)**, standard care is now **immediate triple therapy**: Modified-Release Metformin + SGLT2i + Subcutaneous Semaglutide (titrated up to 1mg weekly).

Target Early-Onset and Obesity

- **Under 40s:** Patients diagnosed with Type 2 diabetes before age 40 are at massive lifetime risk of complications. NICE heavily prioritises them for early GLP-1 RA or tirzepatide introduction.

The New Continuation Rule:

- The restrictive rule requiring a 1% HbA1c drop and 3% weight loss within 6 months has been **abolished** when used for cardiovascular protection.

⚠️ CRITICAL PRIMARY CARE CONTRAINDICATION:

Do NOT co-prescribe a GLP-1 receptor agonist (or tirzepatide) alongside a DPP-4 inhibitor (e.g., sitagliptin). If escalating to a GLP-1, you must explicitly code and stop the DPP-4i.

Insulins & Safety "Sick Day Rules"

Supply Navigation:

- The 2026 update addresses severe market shortages and withdrawals.
- GPs must prescribe all insulins by brand name, never generically, to prevent accidental pharmacy substitutions.

The Primary Care "Sick Day" Script: See next slide “SADMANS”

GPs must counsel patients on pausing medications during acute illness (vomiting, diarrhoea, or severe dehydration):

➢ **Pause Metformin:** Risk of lactic acidosis.

➢ **Pause SGLT2i:** Risk of euglycaemic Diabetic Ketoacidosis (DKA).

➢ **Pause GLP-1s:** Risk of worsening acute dehydration.

The "SADMANS" Patient Script (Barnsley Sick Day Rules)

- Instruct patients to **temporarily suspend** these medications during acute illness featuring dehydration, vomiting, diarrhoea, or fever:

- **S** - Sulfonylureas (e.g., Gliclazide—Barnsley's first-choice SU)
- **A** - ACE Inhibitors
- **D** - Diuretics
- **M** - **Metformin** (standard or prolonged-release)
- **A** - ARBs
- **N** - NSAIDs
- **S** - **SGLT2 Inhibitors** (critical risk of **Euglycemic DKA**)

Barnsley Primary Care Action Grid	
Clinical Indicator	**Immediate 1st Line Treatment**
Standard No comorbidities	M/R Metformin + SGLT2i (Sequentially)
HF, Or CKD, Established ASCVD	M/R Metformin + SGLT2i TRIPLE: M/R Metformin + SGLT2i + GLP-1 RA
Early Onset (<40 years old)	Flag for DSN Team: Early Tirzepatide

Case Study 1: The ASCVD Patient (GPs Navigating Amber-G Drugs)

David, aged 61, a patient at a Barnsley GP practice. History of myocardial infarction 3 years ago.

Current Meds: Metformin 500mg BD, Ramipril 10mg OD, Atorvastatin 80mg OD, Sitagliptin (DPP-4i) 100mg OD

Current Metrics: HbA1c 62 mmol/mol, BMI 31 kg/m^2, eGFR 74 $mL/min/1.73m^2$. Experiencing mild GI bloating from standard metformin.

Questions;

Can a GP practice write the first script for a GLP-1 RA for David tomorrow morning?

What needs to happen to his current Sitagliptin prescription?

Case Study 2: The High-Risk CKD Patient (The South Yorkshire Tirzepatide Pathway)

- **Patient Profile:** Sunita, aged 54. Diagnosed with Type 2 diabetes 6 years ago.
- **Current Meds:** Metformin 1g BD, Gliclazide 80mg BD.
- **Current Metrics:** HbA1c 54 mmol/mol, **BMI 36.5 kg/m²**. Her latest routine bloods show an **eGFR of 48 mL/min/1.73m²** and a urine albumin-to-creatinine ratio (**uACR) of 34 mg/mmol**.

Questions

Sunita is stable at 54 mmol/mol. Does she meet the South Yorkshire ICB criteria for Tirzepatide?

What is her primary organ-protection priority?

Reference Links

- Overview | Type 2 diabetes in adults: management | Guidance | NICE
- https://diabetesonthenet.com/diabetes-primary-care/factsheet-nice-ng28-feb-2026/
- Major changes to type 2 diabetes treatment could save thousands of lives | NICE
- NICE widens access to SGLT-2 inhibitors and GLP-1s in updated type 2 diabetes guidance - The Pharmaceutical Journal
- https://www.google.com/url?sa=t&source=web&rct=j&url=https%3A%2F%2Fwww.nice.org.uk%2Fguidance%2Fng28%2Fchapter%2FInitial-medicines&ved=0CAEQ1fkOahcKEwio8tW0m8WVAxUAAAAAHQAAAAAQQA&opi=89978449
- Editorial: NICE NG28 update: tailoring type 2 diabetes management and cardiorenal health - DiabetesontheNet