Type 2 Diabetes scope SH subgroup discussions Group 2 Date: 6 September 2022	
Population	Are there any specific subgroups that have not been mentioned? Can any of the subgroups be de-prioritised? • Lot of guidelines from ADA and AACE that all highlight NASH, fibrosis in liver being a separate risk factor for cardio vascular disease risk. Liver could be considered a subgroup but nothing about how it is diagnosed. New data available CT1 directly links to cardiovascular disease hospitalisation and other well-known cardiovascular disease events. • Suggest population of NASH is something that should be looked at, there is a lot of data. • NASH – considered as a subgroup or an outcome? Ideally an outcome. • Amputation and Diabetic foot disease/foot ulcers, have highest cardiovascular risk – should have specific instruction should benefit from SGLT2. Outcome or subgroup? Specific population subgroup if possible. • Patient perspective – sometimes there are alternatives to amputation that aren't encouraged in a medical model. • Need patients with direct experience with alternative approaches. • Preventative stages before pharma comes into place – important to remember this. Diabetes UK did survey and has good evidence on low calorie diet for example. Link/collaboration between first line therapy for T2D better between meds as well as lifestyle factors (other guidelines exist, particularly in early stages where so much can be done with diet and lifestyle). • Mental health - Hb1c and BMi and LDL, clinical language of diabetes as opposed to behaviour changes etc. Patients need to be aware that they may have possible mental health complications.
Key issues and draft questions	Any comments on these questions? Can any drugs/classes be omitted? We do not propose updating insulin-based treatments compared to one another, do you have any comments on this? • Group of drugs – sulfonylureas – very niche or not included, efficacy is poor, compliance from patients is poor. Would it be used for comparator for other drugs for NMA possibly? It's a class of drugs that is often used as a comparator. • TAs will look at upcoming drugs.

	• Insulin – might be some clinicians that don't agree that insulin treatment translates from type 1 to 2 diabetes. Worth checking where there is crossover and where there isn't, very different treatment for 1 and 2. • Different positioning – type 1 is take medicines, type 2 – tends to be more asymptomatic, take into consideration different behavioural approaches to help with medicines taking. Very different. Outside scope for this guideline but can be fed back. • Happy with the questions, quite thorough.
Critical issues	Are there any critical issues relating to medicines for T2D that aren't included in the scope? Any safety issues? Areas with the greatest potential for improved patient outcomes? Areas with potential for NHS resource savings?
Outcomes	Any comments on the outcomes? • Apart from changes in lipid levels, nothing included about liver. Looking at change in the characteristics of the liver would help position different patients in terms of additional risk. Invasive biopsy which has multiple complications associated and patient unfriendly or use imaging bio-markers, non-invasive bio-markers for liver disease activity (first sign of NASH). • In renal events – more emphasis of diabetic kidney disease. Also cardiovascular – we are mainly focussing on MI. Not including peripheral vascular disease. In serious adverse events – fractures and amputations. Nothing included about foot fractures, amputation etc. Should be named specifically as a serious adverse event. • Waist circumference important to add?
Health economics model	Any comments on HE modelling for this guideline? • Standard of care NPH insulin is archaic. • All the QALYs on over a patient's lifetime, that will imply once they start treatment the comparisons are made up to the end of that person's life – in high risk populations the outcomes occur much faster and outcomes take longer, but a lifetime implies that treatment changes are less dynamic, whereas in fact patients with diabetes are developing

	comorbidities, glycaemic control potentially better, would 10 years be better. Introducing shorter timeframes sensible? Although it's a lifetime, the dynamic changes are included in the analyses. This is the standard approach in HE. But can feedback how we deal with shorter term outcomes.
GC membership	Any comments on the committee membership composition? • Patient advocate groups • Dietician • Endocrinologist with interest in hepatology • Specialist lipidologist