Type 2 Diabetes scope SH subgroup discussions Group 3 Date: 6 September 2022	
Population	Are there any specific subgroups that have not been mentioned? Can any of the subgroups be de-prioritised? • Happy to see youth onset and elderly frailty in the groups. Ethnicity as part of those subgroups? • Compounding of risk factors – does the modelling cover that? Medicines thresholds could change when risk factors compound • Importance of comorbidities, history for smoking, hypertension, gout • Current modelling does cover any of these groups • Ethnicity in UKPDS 83% white etc • Current trials have requirements for women, ethnicities etc – but past trials don't. • Could we use COVID dataset as a proxy? Or the National Diabetes Audit as database • Are we excluding people below BMI 30? No, we aren't excluding. • BMI is arbitrary in some cases, is it a value add metric, other metrics are far better • More about people living with obesity rather than a single BMI number. We are limited by the data that is reported. There is a value in BMI – it isn't perfect. Needs context especially when it comes to ethnicity • BMI is the easiest measure that anyone in healthcare can easily do in primary care setting. Possible re-wording to "where weight is of an issue". • Doesn't think any groups can be de-prioritised • 80+ section is arbitrary number to avoid over treatment of people in this group. There is overlap with frailty group, but there is a Ven diagram that leaves a group not covered so is needed. • Ethic groups, all ethnicities, if not where are we getting this list? • cautious of listing ethnicities – "Wary of saying south Asian where there are differences between Bangladeshi vs Indian vs Pakistani" Making a defined list of ethnicities could limit the groups we could look at • Aligning of wording for things such as heart failure, chronic kidney disease, cardiovascular etc • Just type 2 – what about LADA and MODY – are these covered appropriately?

	• Other possible groups Learning difficulties in diabetes, cognitive impairment (could be rolled into frailty group?) • Crossover with CG181 – atherosclerotic cardiovascular disease. Lipid modification therapies. • The draft scope indicates that lipid modification and other CV interventions in this update • Need clear crossover and signposts to other guidance that is linked – other European guidance gives time to CVD in diabetes guidance. Aggressive risk factor control will be a topic missed between this guidance and CG181. • CVD needs to be discussed – You die with diabetes from complications, the main one of concern being the CVD
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? • 2nd generation basal insulin analogues • Finerenone – where does this drug sit? It has benefit in population but not a Glucose medicine. Happy with this being mentioned or signposted. • These medicines touch on other therapies in other guidelines. Guidance needs to be clear to healthcare providers to help them manage risk across other appropriate guidance. • Guidance will be too complicated if incorporates other medicines that happen to benefit type 2. Standalone core medications should be looked at. Insulin needs to be included as a class of drug – lots of patients still end up here. • Does the full combinations of pharma interventions need to be outlined in the guidance. Through 1st line 2nd line etc. "precision medicine" for cost effective primary care prescription • Consensus – to keep focus on type 2 glucose specific medicines
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? • Scope has all the right elements, groups, medicines etc • combinations of medicines? yes questions cover combinations • Dual therapy – Vildagliptin – VERIFY trial. Also will have sitagliptin evidence 2024. GRADE study American study. Some gliptins will come off patent soon.

Outcomes	Any comments on the outcomes? • Changes in lipids or blood pressure on their own? • Is the order of outcomes significant? Relevancy to patients? Outcomes crossover guidance a lot – heart failure, CKD. What sort of guidance are NICE trying to offer here? Wants signposts between guidance to be extremely clear. • List goes beyond glucose control because if it didn't, we wouldn't capture all the benefits and risks of different treatments. • Outcome priorities and presentation order should be considered when presenting the actual guideline. • Micro vascular complications, patient reported outcomes (PROMS), TriMaster trial has PROMS – taking medication and being happy about it • Importance of having as many outcomes as possible to factor any benefits into cost effectiveness calculation • Ignore the order of outcomes • HbA1c covers complications down the line like micro vascular complications • Current list is good. • Remission should be a main patient outcome
Health economics model	Any comments on HE modelling for this guideline? • GLP1 usage – well known from previous guideline • NPH still standard? Compare different insulins? Biosimilars now available for basal insulin analogues • Anything more than 10 years old is irrelevant now – dataset needs to be current and contemporary for background risks. • Different levels of standard of care – ADA EASD guidance should be the NICE standard of care. NICE should aim high. • Agrees standard of care needs to be looked at by NICE – should be upgraded if it's possible • Last guideline did upgrade standard of care • Agrees difference on the ground can be large, special interest gp versus general gp for example.
GC membership	Any comments on the committee membership composition?

General notes

- Lifestyle interventions importance. Possible comparison of drugs vs lifestyle interventions.
- Large lifestyle interventions if successful can lead to huge weight loss and change medicine interventions.

Key points for feedback to plenary session

- Populations
    - Atherosclerotic heart disease
    - CKD not renal impairment
    - Learning disabilities
    - Neither Type 2 Nor Type 1
    - Multimorbidity
- Interventions
    - 2nd generation basal insulins
    - SGLT2s vs Statins and relationship with other NICE guidance
    - Lifestyle intervention
- Outcomes
    - Include all as feed in to the model
    - Microvascular outcomes (but A1c is a proxy)
    - Ordering – outcomes important to patients seem to be low down
    - Remission
- Modelling
    - Standard care is not reflective of current practice
        - E.g. is NPH still relevant
    - Contemporary data for background risks