PUBLIC HEALTH PROGRAMME GUIDANCE

PREVENTION OF TYPE 2 DIABETES: PREVENTING PRE-DIABETES

Draft Scope Consultation – Stakeholder Response Table

From 20 May to 18 June 2009

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Black and Ethnic Minority Diabetes Association		General	a) Using the term 'pre-diabetes' to describe the condition will improve the understanding of the lay person than using the term 'raised and impaired blood glucose levels' especially among high-risk groups.	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.
Black and Ethnic Minority Diabetes Association		General	b) There is no mention of Gay and Lesbian people who are diabetic in the DRAFT SCOPE. Their perception of pre-diabetes and diabetic conditions may be different from other people in terms of the need to take 'pre-diabetes' a serious health condition that can degenerate into Type 2 diabetes with the attending preventable complications.	Thank you for raising this issue, the scope has been amended to make it clear that evidence pertaining to gay and lesbian people will be actively sought. Where studies make reference to gay and lesbian groups or individuals this will be reported in the evidence reviews.

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Black and Ethnic Minority Diabetes Association		General	c) The current feedback from a Gay participant during a Patient and Public Involvement Consultation meeting is 'no one cares…….no one wants to know'.	Thank you for highlighting this issue. As above, the scope has been amended to make it clear that evidence pertaining to gay and lesbian people will be actively sought. Where studies make reference to gay and lesbian groups or individuals this will be reported in the evidence reviews.
Black and Ethnic Minority Diabetes Association		General	d) The impact of diabetes on Gay and Lesbian people may add a different dimension to diabetes care.	Thank you for highlighting this issue. As above, the scope has been amended to make it clear that evidence pertaining to gay and lesbian people will be actively sought. Where studies make reference to gay and lesbian groups or individuals this will be reported in the evidence reviews.
British Dietetic Association		General and 4.1.1	It is a shame that the scope will be restricted to over 18s – The BDA appreciate that this makes it an easier project to manage but much of the same applies to under 18s and it seems unlikely that this will be addressed separately. Type 2 diabetes is increasing significantly in the under 18 age group and this needs to be addressed. Interventions should ideally be directed specifically at younger/ high risk individuals where the risk of developing type 2 earlier means there is greater risk of reduced quality of life due to	Thank you for your comments. The guidance will not be extended to children and young people under 18 years of age. Considering adulthood to start at age18 is in line with the NICE guidance on the prevention and management of obesity. The type of interventions that may be effective, and the type of professionals for

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			potential earlier onset of complications	whom the guidance would apply, would be quite different for children and adults. Extending the scope to under 18s would mean that we could jeopardise giving vulnerable groups in adulthood or childhood sufficient consideration. However, we agree that this is a key area for consideration, particularly due to the rise in cases of type 2 diabetes and prevalence of obesity in children and young people. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
British Dietetic Association		3b	This section gives waist circumference measures which are indicative of increased risk. However, these are figures for the caucasian population. The South Asian population have a higher risk at lower waist circumference and BMI. The lower figures for the South Asian population should probably be quoted in the document	Thank you for your comments. We are aware of the international debate concerning thresholds for being classified as overweight and obese for different ethnic groups. Consideration of the most appropriate cut off points for BMI and waist circumference for

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				different BME groups is outside the remit of this guidance. This issue was considered as part of the NICE guidance on the prevention and management of obesity (see recommendation 1.2.2.8), and will most likely be re-considered when that guidance is next updated. However, we have decided to extend the groups at risk to overweight individuals (25 to 30 kg/m^2). We are aware that a WHO working group is currently undertaking a further review and assessment of available data on the relation between waist circumference and morbidity and the interaction between BMI, waist circumference, and health risk. For further details see: http://apps.who.int/bmi/index.jsp?introPage=intro_3.html. We will keep a watching brief on this work.

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British Dietetic Association		3c	Many people are indeed unaware of their risk of developing diabetes but are equally unaware of the impact of a diagnosis of diabetes (i.e impact of living with diabetes and its potential complications)	Thank you for your comments.
British Dietetic Association		3f	Agree -most PCT's have the ability through QOF to identify high risk individuals via BMI records etc. These record are clearly not being used for this purpose in the majority of cases	Thank you for your comments.

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City Hospitals Sunderland		General	As Type 2 Diabetes and metabolic syndrome are now becoming common in children and adolescents, I strongly feel that the scope of the guidance should also include this age group. Waiting until a patient with metabolic syndrome and hyperinsulinaemia is 18 does not make sense.	Thank you for your comments. The guidance will not be extended to children and young people under 18 years of age. Considering adulthood to start at age18 is in line with the NICE guidance on the prevention and management of obesity. The type of interventions that may be effective, and the type of professionals for whom the guidance would apply, would be quite different for children and adults. Extending the scope to under 18s would mean that we could jeopardise giving vulnerable groups in adulthood or childhood sufficient consideration. However, we agree that this is a key area for consideration, particularly due to the rise in cases of type 2 diabetes and prevalence of obesity in children and young people. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Department of Health		General	We welcome the widening of the parameters of the guidance to acknowledge and address action for all high-risk groups. However, the draft does not appear to mention specifically, people with severe mental illness or learning disabilities, in the groups that the guidance will cover.	Aspects of the guidance may apply to people with severe mental illness or learning disabilities. However, specific issues on the prevention of type 2 diabetes for people with severe mental illness or learning disabilities are outside the remit of this work due to the possible role of drug treatments in pre-disposing individuals to type 2 diabetes and/or particular clinical or other issues which may either increase their risk, or influence the nature and delivery of intervention. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Department of Health		2 (a)	For practical purposes, we would prefer the use of the term 'pre-diabetes' for describing raised and impaired blood glucose levels (in this context, pre-diabetes is defined by the World Health Organisation terminology of impaired fasting glucose and/or impaired glucose tolerance).	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.
Department of Health		2 (d)	Whilst this section highlights that the guidance will make recommendations for good practice for the population as a whole, we feel that it would be advantageous to be more explicit earlier in the draft about a focus on reducing the prevalence of pre-diabetes amongst those at greatest risk in disadvantaged groups.	Thank you for your comments. We have amended the scope as suggested.

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Department of Health		3 (a)	The draft scope states that *'during that time, they may also be developing other medical conditions such as retinopathy and an increased risk of coronary heart disease'*. In our view this is incorrect, as pre-diabetes is not associated with retinopathy. The definition of diabetes is defined by micro-vascular damage. We believe however, that there is an increased risk of coronary heart disease.	Thank you for your comments. The scope has been amended for clarity.
Department of Health		3 (c)	The draft scope states that *'improved insulin resistance can prevent pre-diabetes'*. We feel that this should read that there is a need to reduce insulin resistance.	Thank you for your comments. The scope has been amended for clarity.
Department of Health		4.1.3	In our opinion, it would be beneficial to include a reference to 'NHS Health Checks' in the section referring *to 'methods to identify communities and individuals at high risk of developing pre-diabetes'*. The NHS Health Check programme is a universal and systematic programme for everyone aged between 40 and 74 years that will assess people's risk of heart disease, stroke, kidney disease and diabetes, and will support people to reduce or manage that risk through individually tailored advice.	Thank you for your comments. Health checks are not specifically mentioned in 4.1.3 but are highlighted elsewhere in the scope. In addition, 4.1.3(b) states that "It may also include opportunistic screening in primary care". Screening and diagnostic tests are outside the remit of this particular piece of guidance, however, screening may form part of the focus for the second piece of guidance on preventing the progression of pre-diabetes to type 2 diabetes.

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Diabetes UK		2a	Diabetes UK would like to recommend that the term "pre-diabetes" is replaced with the terms "impaired glucose regulation" (IGR) or "non diabetic hyperglycaemia". These terms are preferred because they more accurately describe the condition and do not imply that people will go on to develop Type 2 diabetes. However consideration needs to be given to how this increased risk of Type 2 diabetes should be communicated to the public. Diabetes UK has analysed the literature in this area. This points to problems with the use of the term "pre diabetes". The issues are: • Not all people with "pre diabetes" will go on to develop Type 2 diabetes and some may revert to normoglycaemia[1] • The condition "label" can lead to individuals reacting negatively to this, and any interventions they are given to help prevent diabetes.[2] • We know that people with diabetes are already unfairly discriminated against in the workplace or in matters of insurance, therefore again this could lead to similar discrimination.[2] • Since the term "pre diabetes" was created the debate has moved on and this term is no longer considered appropriate.	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.

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			1. American College of Endocrinology Consensus Statement on the diagnosis and management of pre-diabetes in the continuum of hyperglycaemia – when do the risks of diabetes begin? July 23, 2008 2. Montori V M et al. Waking up from the DREAM of preventing diabetes with drugs. BMJ 2007;334:882-884	
Diabetes UK		2c	It would be valuable to include the recent NHS Health Checks report in the list of guidance. NHS Health Check: Vascular Risk Assessment and Management Best Practice Guidance http://www.dh.gov.uk	Thank you for your comments. We have now included NHS Health checks among the list of related policy documents that this guidance will support, in section 2c
Diabetes UK		2d	The document could also be seen as being aimed at professionals involved in delivering physical activity interventions.	Thank you for your comments. The list of groups who the guidance is aimed at has been amended to include professionals involved in delivering physical activity interventions, however, please note this list is not intended to be exhaustive.
Diabetes UK		3b	The figure for the waist circumference in men is incorrect in this section – it currently reads 92cm. Later in the scope it correctly reads 94 cm.	Thank you for highlighting this error; the scope has been amended.
Diabetes UK		3b	The scope at present does not consider the differences in waist circumference for South Asian men. South Asian men are at	Thank you for your comments. We are aware of the international debate

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			increased risk at a lower waist circumference cut off point of: 90 cm (35 inches).	concerning thresholds for being classified as overweight and obese for different ethnic groups. Consideration of the most appropriate cut off points for BMI and waist circumference for different BME groups is outside the remit of this guidance. This issue was considered as part of the NICE guidance on the prevention and management of obesity (see recommendation 1.2.2.8), and will most likely be re-considered when that guidance is next updated. However, we have decided to extend the groups at risk to overweight individuals (25 to 30 kg/m^2). We are aware that a WHO working group is currently undertaking a further review and assessment of available data on the relation between waist circumference and morbidity and the interaction between BMI, waist circumference, and health risk.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				For further details see: http://apps.who.int/bmi/index.jsp?introPage=intro_3.html. We will keep a watching brief on this work.
Diabetes UK		3b	For accuracy please include the word "close" prior to family history. (eg parent/ sibling)	Thank you for your comments. The scope has been amended as suggested.
Diabetes UK		3b	The scope needs to include the fact that people from BAME communities are at risk from a younger age (25 years old) as well as at an increased risk overall[1,2] 1. Epidemiology of type 2 diabetes: Indian scenario Indian J Med Res 125, 2007; 217-230 V Mohan, S Sandeep, R Deepa et al Chan JCN, Malik V et al. Diabetes in Asia. Epidemiology, risk factors and pathophysiology. JAMA, May 2009 – Vol 301, No.20	Thank you for highlighting this issue; the scope has been amended as suggested.

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Diabetes UK		3b	A number of additional risk factors need to be included. These are: - A history of high blood pressure, heart attack, or stroke[1] - Polycystic Ovary Syndrome with overweight[2] - People with Severe Mental Illness[3] 1. Coronary Heart Disease NSF: Chapter Two: Preventing coronary heart disease in high risk groups. *Department of Health*. 2000. 2. Kar PS, Cummings MH. Polycystic ovary syndrome. Practical Diabetes International. September 2005. Vol. 22 No.7 3. Holt R, Peveler R. Hyperglycaemia and diabetes in patients with serious mental illnesses. A quick reference guide.2004	Aspects of the guidance may apply to people with severe mental illness or a history of high blood pressure, heart attack or stroke. However, specific issues on the prevention of type 2 diabetes for people with severe mental illness or learning disabilities are outside the remit of this work due to the possible role of drug treatments in pre-disposing individuals to type 2 diabetes and/or particular clinical or other issues which may either increase their risk or influence the nature and / or delivery of intervention. The guidance will apply to overweight or obese women with PCOS due to their weight but the management of their condition more generally is outside the remit of this work. If you feel that any of these areas are worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Diabetes UK		3c	It would be useful to identify in this section that the NHS Health Checks will help to identify early people at risk of CVD including Type 2 diabetes.	Thank you for your comment. We have now included NHS Health checks among the list of related policy documents that this guidance will support, in section 2c
Diabetes UK		3e	Studies have also demonstrated the cost effectiveness of screening for IGR particularly as this can lead to early identification, and interventions aimed at lifestyle modification which can help to prevent Type 2 diabetes. 1. Hoerger T J et al. Cost-effectiveness of screening for pre-diabetes among overweight and obese U.S. Adults. Diabetes Care 30:2874-2879, 2007 Gillies et al. Different strategies for screening and prevention of type 2 diabetes in adults: cost effectiveness analysis. BMJ 2008 336: 1180-1185.	Thank you for providing this information. Screening is outside the remit of this particular piece of guidance but may form part of the focus for the second piece of guidance on preventing the progression of pre-diabetes to type 2 diabetes..
Diabetes UK		4.1.1	Diabetes UK questions to age cut off point of 70 years of age, particularly as the NHS Health Checks are aimed at adults up to the age of 74.	Thank you for raising this issue. We will increase the age cut off for the guidance to 74 years of age in line with the NHS Health Checks.

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Diabetes UK		4.1.1	Again several risk factors need to be included: - A history of high blood pressure, heart attack, or stroke[1] - Polycystic Ovary Syndrome with overweight[2] - People with Severe Mental Illness[3] - Women with gestational diabetes[4] 1. Coronary Heart Disease NSF: Chapter Two: Preventing coronary heart disease in high risk groups. *Department of Health*. 2000. 2. Kar PS, Cummings MH. Polycystic ovary syndrome. Practical Diabetes International. September 2005. Vol. 22 No.7 3. Holt R, Peveler R. Hyperglycaemia and diabetes in patients with serious mental illnesses. A quick reference guide.2004 4. http://guidance.nice.org.uk/CG63/Guidance/pdf/English	Please see previous response in relation to a history of high blood pressure, heart attack or stroke; PCOS; mental illness. In relation to gestational diabetes, women with a history of gestational diabetes are highlighted in the scope as a high risk group. However, gestational diabetes during pregnancy per se is outside the remit of this scope (there is already existing NICE guidance on diabetes in pregnancy, which includes gestational diabetes – see http://guidance.nice.org.uk/CG63)
Diabetes UK		4.1.1	The BMI cut off points for people from South Asian communities is lower (25 kg/m2) than existing cut off point of 30 kg/m2. Please also include this figure[1] 1. Snehalatha C, Viswanathan V and Ramachandran A (2003). Cutoff values for normal anthropometric variables in Asian Indian adults. *Diabetes Care*; 26(5):1380–1384	Please see previous response in relation to the most appropriate BMI or waist cut off for people from South Asian communities. However, we have decided to extend the groups at risk to overweight individuals (25 to 30 kg/m^2).

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Diabetes UK		4.1.4a)	Diabetes UK questions why NICE are not considering population level screening – is this because if the NHS Health Checks programme?	Thank you for your comments. NHS Health Checks has been added to section 2c. We will consider all appropriate evidence relevant to the scope based on the referral from the Department of Health. Please note that population level screening is under the remit of the National Screening Committee.
Diabetes UK		4.1.4 b)	Diabetes UK questions why diagnostic testing to identify IGR is not included in the measures to be covered. Guidance on this issue would be valuable, particularly in light of the use of Hba1c as a diagnostic measure.	Thank you for your comments. The referral from the Department of Health was for NICE to develop public health guidance on prevention of type 2 diabetes in high risk groups. Diagnostic tests are not included in the referral.. If you feel that diagnostic testing is worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Diabetes UK		4.1.4 c)	Diabetes UK would like to question why BMI and waist circumference to assess risk in BAME communities will not be covered. Particularly as these differ for different communities and are a significant indicator of risk.	Please see previous response.

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Diabetes UK		4.2	Changes in clinical practice are likely to be an expected outcome.	Thank you for this comment. The list of expected outcomes is not intended to be exhaustive.
Gurayat Diabetes Center		1	• I suggest to modify the title to (Prevention of type 2 diabetes: Preventing pre-diabetes among adults in high risk groups) • The term pre-diabetes is preferred to describe the glucose abnormality before diabetes occur	Thank you for your comments. The title will be amended as suggested.
Gurayat Diabetes Center		2 (d)	• Prediabetes condition should be defined	Thank you for your comments. We will more clearly define the term pre-diabetes in the final scope.

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Gurayat Diabetes Center		3 (b)	• Overweight (BMI 25-30) is also consider risk factor for pre-diabetes, why we ignore it and consider only obesity • Abnormal waist circumference varies based on ethnicity, so we should clarify the stated figures (more than 80cm for women and more than 92cm for men) belong to which ethnicity and what about other ethnicities	Thank you for your comments. Consideration of the most appropriate cut off points for BMI and waist circumference for different BME groups is outside the remit of this guidance. This issue was considered as part of the NICE guidance on the prevention and management of obesity (see recommendation 1.2.2.8), and will most likely be re-considered when this guidance is next updated. However, we have decided to extend the groups at risk to overweight individuals (25 to 30 kg/m^2).
Gurayat Diabetes Center		4.1.3 (b)	• The methods of identifying communities and individuals at high risk to developing pre-diabetes should be included and describe well for the guideline users.	Thank you for your comments.

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Gurayat Diabetes Center		4.1.4 (b)	• As long as the risk factors to develop pre-diabetes and risk factors to develop diabetes in pre-diabetic patients are not different especially when prediabetic patients are asymptomatic. I think we need to test high risk groups or individuals for the presence of pre-diabetes and theses tests should be included in this guideline.	Thank you for your comments. The referral from the Department of Health does not include a remit to consider diagnostic tests within this guidance. If you feel that diagnostic testing is worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
NHS Direct		General	The scope has been reviewed by NHS Direct and the development of the guideline is welcome.	Thank you.
National Heart Forum		General	The National Heart Forum is very supportive of the need to develop public health guidance on the prevention of type 2 diabetes mellitus among high risk groups.	Thank you.
National Heart Forum			Whilst NHF acknowledge that the focus on high risk groups represents a different focus to the approach of the ongoing prevention of cardiovascular disease at population level, there will undoubtedly be considerable overlap, we hope that this enquiry will take the opportunity to explore in more depth some of the issues raised in this enquiry. Particularly how to make interventions successful with high risk groups.	Thank you your comments. Relevant issues raised during the development of the CVD guidance will be considered.

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National Heart Forum		Groups that will be covered 4.1.2	The NHF are concerned that by limiting the scope to adults with Type 2 Diabetes the enquiry will fail to recognise address the increasing burden of Type 2 diabetes amongst children due to the increasing rates of obesity predicted in work by the NHF for the Foresight Obesity enquiry.	Thank you for your comments. The guidance will not be extended to children and young people under 18 years of age. The type of interventions that may be effective, and the type of professionals for whom the guidance would apply, would be quite different for children and adults. Extending the scope to under 18s would mean that we could jeopardise giving vulnerable groups in adulthood or childhood sufficient consideration. However, we agree that this is a key area for consideration, particularly due to the rise in cases of type 2 diabetes and prevalence of obesity in children and young people. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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National Heart Forum		4.1.3a)	RE awareness raising, the NHF are currently developing an online obesity learning centre for the Department of Health for the provision of information to health and associated professions we hope the enquiry will consider novel methods of awareness raising.	Thank you for bringing this work to our attention. We would welcome receiving further information on the initiative once available.

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Newcastle University - Institute of Health and Society		2 (a)	**Terminology for 'raised and impaired glucose levels':** **Use of the term pre-diabetes:** • is inaccurate for people who do not progress to T2D • has implied inevitability that is not helpful, suggesting 'it will happen anyway' and thus may be a barrier to engaging the public in active prevention measures • from our experience with the Newcastle arm of the European Diabetes Prevention Study (ISRCTN 15670600) and our associated qualitative study we identified the fact that the participants knew they did not have diabetes as a motivating factor[1]. The participants were diagnosed with IGT and they were aware of their risk, but to them the fact that this was "not diabetes" was important. • we can appreciate why some doctors might think the term pre-diabetes is helpful in talking to patients, but suggest this term is not appropriate for the scientific literature or public health guidance • we can appreciate that this may make the condition be taken more seriously by public & health professionals alike, but we suggest a need to be careful of legal implications (e.g. Insurance etc.) of having diabetes mentioned at all. Cont'd	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.
Newcastle University - Institute of Health and Society		2 (a)	**Use of the term 'at risk of T2D':** • explains the situation well • but does not distinguish between people with 'raised and	See above.

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			impaired glucose levels' and the risk groups who do not have either IFG or IGT **Possible alternative terminology:** Abnormal blood glucose levels Raised or abnormal blood glucose levels Impaired Glucose Regulation, Dysglycaemia, Intermediate Hyperglycaemia.	
Newcastle University - Institute of Health and Society		3 b)	Risk factor: We suggest smoking as a risk factor should be included, particularly as smoking cessation groups may provide an opportunity to access an at risk group[2, 3].	Thank you for your comments. Smoking is outside the remit of this work. Smoking is covered extensively in other, existing NICE guidance (see http://www.nice.org.uk/Guidance/PHG/Published). We will consider all appropriate evidence relevant to our scope and review questions, and if there is evidence about the effectiveness of settings such as smoking cessation groups for intervention then it will be taken into account when developing the guidance.
Newcastle University - Institute of Health and Society		3 b)	Risk factor: we suggest that it would be appropriate to include differential waist circumference cut offs for ethnic minority high risk groups. It is difficult to see how waist measures can be used at all	Thank you for your comments. We are aware of the international debate concerning thresholds for being classified

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			unless provision is included for differential cut offs. In communications with the public it would be helpful to give waist circumference cut-offs in inches as well as cm, as the public still thinks of their waist in inches and this is how clothes are mostly organised and sold in the UK (see also section 4.1.1)	as overweight and obese for different ethnic groups. Consideration of the most appropriate cut off points for BMI and waist circumference for different BME groups is outside the remit of this guidance. This issue was considered as part of the NICE guidance on the prevention and management of obesity (see recommendation 1.2.2.8), and will most likely be re-considered when that guidance is next updated. However, we have decided to extend the groups at risk to overweight individuals (25 to 30 kg/m^2). We are aware that a WHO working group is currently undertaking a further review and assessment of available data on the relation between waist circumference and morbidity and the interaction between BMI, waist circumference, and health risk. For further details see:

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				http://apps.who.int/bmi/index.jsp?introPage=intro_3.html. We will keep a watching brief on this work. The PDG may consider the most appropriate way to communicate any recommendations on waist circumference to different audiences, as appropriate.
Newcastle University - Institute of Health and Society		3 b)	Risk factor: we suggest the division of family history into separate groups such as: 'immediate family' and 'other relations'. There is no mention in the draft scope of genetic predisposition (other than family history) If this is not to be included we suggest there should be a mention of the fact that it has been excluded and a rational for this exclusion.	Thank you for your comments. Genetic predisposition is not excluded. The term "family history", used in section 3b will include both genetic and environmental factors. These issues may be explored in more detail in the evidence reviews and guidance. Where appropriate we will ensure that we highlight that risk is for "close" family members.
Newcastle University - Institute of Health and Society		3 b)	Risk factor: a high fat diet is not included. We suggest dietary quality is both an important risk factor and also modifiable for these reasons this should be included	Thank you for your comments. Diet and other aspects of lifestyle are considered modifiable risk factors which will be considered for intervention (as expected outcome number 4 in section 4.2), depending on the evidence available.

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Newcastle University - Institute of Health and Society		3 b)	Risk factor: hypertension. We suggest this is a risk factor that will be routinely identified in primary care and is covered in the new NHS CVD screening policy. Hypertension should be included even if only to explain how it is covered elsewhere.	Aspects of the guidance may apply to people with pre-existing conditions such as hypertension. However, specific issues on the prevention of type 2 diabetes for people with pre-existing conditions are outside the remit of this work due to the possible role of drug treatments in pre-disposing individuals to type 2 diabetes and/or particular clinical or other issues which may either increase their risk or influence the nature of intervention.
Newcastle University - Institute of Health and Society		3 c) f)	Raising awareness: this is an important issue and includes considering ways to raise awareness out with the Health Service to improve the reach. It might be difficult for people working in Health Services to appreciate this lack of awareness in the general population.	Thank you for raising this issue. NICE public health guidance is not restricted to people working in the NHS. Section 2d highlights that the guidance is "aimed at professionals, commissioners and managers with public health as their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors".
Newcastle University - Institute of Health and Society		3 b)	There is a need for clarity in relation to socioeconomic trends. We suggest the scope should identify data about socioeconomic trends in prevalence of 'pre-diabetes'. Data on socioeconomic trends in diabetes related mortality is less relevant as there could	Thank you for highlighting this issue.

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			be reasons other than the prevalence of the pre-disease state for increased mortality.	
Newcastle University - Institute of Health and Society		3 e)	Cost: evaluating cost effectiveness is important and the need for this could be more clearly emphasised	Thank you for this comment. The cost effectiveness aspects of the work are highlighted in section 4.2 For further information on how the health economics data is collected and analysed please refer to chapter 6 in the NICE public health methods manual: http://www.nice.org.uk/media/2FB/53/PHMethodsManual110509.pdf
Newcastle University - Institute of Health and Society		4.1.1	Age range: as discussed at the stakeholder meeting, including a younger age group is relevant where there is family history of T2D and in groups at greater risk. Incidence and prevalence of T2D are increasing among teenagers. Perhaps the lower limit could be reduced to 16 here and separate guidance on preventing future risk of T2D in children could be prepared?	Thank you for your comments. The guidance will not be extended to children and young people under 18 years of age. Considering adulthood to start at age18 is in line with the NICE guidance on the prevention and management of obesity. The type of interventions that may be effective, and the type of professionals for whom the guidance would apply, would be quite different for children and adults. Extending the scope to

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			In addition we would like some explanation why older people (over 70) are excluded. If they are covered elsewhere this should be clarified. There is no clear reason why over 70s should be excluded.	under 18s would mean that we could jeopardise giving vulnerable groups in adulthood or childhood sufficient consideration. However, we agree that this is a key area for consideration, particularly due to the rise in cases of type 2 diabetes and prevalence of obesity in children and young people. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp The upper age limit of the guidance has been amended to 74 years of age, in line with the NHS Health Checks.
Newcastle University - Institute of Health and Society		4.1.1	SES "identified by education and occupation" – does this mean they would need both measures? Does it mean either or? Why just these measures? Why not "as measured by any of the standard measures of SES currently in use in the UK. SES: identifying lower SES by location (by post code, using index of multiple deprivation) will be important to identify at risk	Thank you for your comments. The final scope will be amended to state "….socioeconomic group (as measured, for example, by education or occupation).

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			communities, since occupation and educational attainment are not routinely available. The same may apply to identifying ethnic communities (4.1.3).	
Newcastle University - Institute of Health and Society		4.1.3	Of the five core activities listed in this section, only one relates directly to prevention and the others are about identification of high risk groups. ▪ Perhaps it would be helpful to incorporate 'identification' in the title. This could help those searching for guidance to find the right document – if you want to know about identification you might not think 'prevention' guidance is the relevant one. ▪ Would like to see greater clarity about the prevention advice to be given as part of the measures to be covered (e.g. what is the best dietary advice to give as well ways of helping high risk groups to adopt better dietary habits) ▪ The focus on prevention in the title is not reflected in the single 'prevention' statement – what levels would we want to achieve? Where is the 'This may include..' clause? This section could also identify the different intervention modalities that might be used individually or in combination, including educational interventions, policy measures, use of technologies and access to resources.	Thank you for your comments. We will ensure that the focus of this guidance is about prevention. The scope outlines one area about identification, two others relate to raising awareness and the other four are about facilitating prevention strategies such as ensuring interventions are culturally sensitive and looking at ways to help people engage in an intervention. The guidance is aimed at considering wide ranging population approaches to reducing pre-diabetes risk rather than a consideration of how to reduce individual risk factors. The focus of this guidance would be on how to tailor general population advice, for example, on dietary habits, for groups considered to be at high risk of developing pre- diabetes. We anticipate that the guidance will cross refer to other NICE guidance, such as

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				guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.
Newcastle University - Institute of Health and Society		4.1.3 d)	Is this about intervention design methodology? Do we have some specific examples of possible methods (e.g. social marketing) to clarify? How will the methods and appropriateness be of the intervention design be assessed?	Thank you for your comments. Section 4.13d outlines the activities/measures that we will consider, depending on the evidence available. It is likely that the PDG will consider the appropriateness of the research methodologies used in any identified quantitative and qualitative research. For further information about public health evidence reviews and the workings of the Programme Development Group, please see: www.nice.org.uk/media/2FB/53/PHMethodsManual110509.pdf
Newcastle University - Institute of Health and Society		4.1.4	Waist: difficult to include waist circumference as an individual risk factor if you do not have differential cut offs for ethnic minority groups (see section 3b)	Please see previous response.

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Newcastle University - Institute of Health and Society		4.1.4	Screening: ▪ There is similarity or overlap with the vascular screening programme that might effectively result in population screening (e..g. use of FINDRISC) ▪ Why is population level screening excluded? Will this be covered elsewhere? What if this is the most effective and cost effective way of identifying people? How does this relate to the second planned IGT/IFG guidance?	Thank you for your comments. NHS Health Checks has been added to section 2c. We will consider all appropriate evidence relevant to the scope based on the referral from the Department of Health. Please note that population level screening is under the remit of the National Screening Committee.
Newcastle University - Institute of Health and Society		4.2	Intervention content: What is the best and most appropriate behaviour change advice for diet and physical activity? What do we want people at risk to do as well as how we can help them to change?	Thank you; we will consider your suggestion when the protocol for evidence reviews is developed. However, as stated above, the guidance is aimed at considering wide ranging population approaches to reducing pre-diabetes risk rather than a consideration of how to reduce individual risk factors. The focus of this guidance is likely to be on how to tailor general population advice, for example, on dietary habits, for groups considered to be at high risk of developing pre- diabetes. We anticipate that the guidance will cross refer to other NICE guidance, for example: • Obesity: the prevention,

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				identification, assessment and management of overweight and obesity in adults and children. • Physical activity and the environment • Promoting physical activity in the workplace.
Newcastle University - Institute of Health and Society		4.2.Q6	Diet advice: is there good evidence for specific dietary advice to prevent pre-diabetes or will this be general healthy eating advice? (i.e. what does 'improve' mean?)	Thank you for your comments. Please see previous response re specific dietary advice. With regards to how 'improve' will be defined, it is not possible to precisely answer this question at this stage before considering the evidence available. Diet will be considered a potentially modifiable risk factor and outcomes may include measures of glucose tolerance or changes in diet per se known to increase or reduce risk of obesity or type 2 diabetes.
Newcastle University - Institute of Health and Society		4.2 EO	This section might be better split into: Design of..... Use of.... Effectiveness of.....	Thank you for your comments. The organisation of this section follows a standard layout for all public health scopes.

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Newcastle University - Institute of Health and Society		4.2 EO 7	This should include "and their complications" since these are a major cost to the NHS and burden on society	Thank you. The scope has been amended in line with your comments.
Newcastle University - Institute of Health and Society		Appendix B	We suggest you add to this: The differential effectiveness and cost effectiveness of different intervention modalities used individually and in combination, including educational interventions, policy measures, technologies and access to resources.	Thank you. Appendix B has been amended in line with your comments.
Newcastle University - Institute of Health and Society		General	How would we know if there was a reduction in incidence of IFG and IGT? Will this come into the second guidance? There is a lot about appropriate interventions, not so much about evaluation and assessment. It would be better if the questions and expected outcomes could tie up (e.g. Q5 not related to O5)	Thank you for your comments. The implementation team at NICE will consider the implementation and update of the published guidance. The incidence of raised and impaired blood glucose levels is likely to be identified through population statistics or individual research studies. Please note that diagnostic tests and screening is outside the remit of this scope, however, screening may form part of the focus for the second piece of guidance on preventing the progression of pre-diabetes to type 2 diabetes. Population level screening is under the remit of the National Screening Committee.

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			We don't see where outcome 8 is covered in the questions. There is policy in this area in many countries as well as European policy, which may not appear in published research. We feel this should be reviewed critically and potentially included?	The list of outcomes is generic, providing examples of what the impact of the completed guidance is likely to achieve. The list of outcomes is not intended to be an exhaustive list. Furthermore, many of the outcomes listed are not exclusive to individual questions but link with several of the questions. Outcome 8 (reduction in health conditions such as high blood pressure) does not relate to a specific question but is likely to be a secondary outcome linked with several of the questions. Existing policy and guidance in UK and other countries may be considered by the PDG.
Newcastle University - Institute of Health and Society			References: 1. Penn, L., S. Moffatt, and M. White, *Participants' perspective on maintaining behaviour change: a qualitative study within the European Diabetes Prevention Study.* BMC Public Health, 2008. **8**(1): p. 235.	Thank you for providing this information.

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			2. Houston, T.K., et al., *Active and passive smoking and development of glucose intolerance among young adults in a prospective cohort: CARDIA study.* BMJ, 2006. **332**(7549): p. 1064-1069. 3. Rimm, E.B., et al., *Prospective study of cigarette smoking, alcohol use, and the risk of diabetes in men.* BMJ, 1995. **310**(6979): p. 555-559.	
Royal College of Midwives		2a	It is not clear why there are going to be 2 pieces of guidance when the condition progresses in a continuum. It would be useful and possibly more accessible to have them as one document.	Thank you for this comment. While we recognise that the condition progresses in a continuum, a pragmatic decision was taken to split this guidance into two to keep the work manageable. This was due to the complexity of preventing type 2 diabetes and the broad range of interventions (and associated issues) that may be considered among population groups and individuals, depending on their level of risk. Splitting the guidance recognises that (1) the opportunities for intervention and (2) most appropriate type of intervention may differ along the continuum of risk. Splitting the guidance should ensure that the work is manageable in the time available

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				and that adequate attention is given to (1) population groups at risk prior to diagnosis of IGT and (2) individuals with a diagnosis of IGT (and therefore confirmed to be at particular risk of developing type 2 diabetes).
Royal College of Midwives		2a	The Royal College of Midwives prefers the term 'pre-diabetes' to 'raised and impaired blood glucose levels' to describe this condition.	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.

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Royal College of Midwives		4.1.2	Is it not clear why 'pregnant women' are not included in the groups that are to be covered in the guidance. We think this group would significantly benefit from the guidance.	Women with a history of gestational diabetes are considered a high risk group and will be included. However, gestational diabetes during pregnancy per se is outside the remit of this scope. There is already existing NICE guidance on diabetes in pregnancy, which includes gestational diabetes (see http://guidance.nice.org.uk/CG63), antental care (see http://guidance.nice.org.uk/CG62) and maternal and child nutrition (see http://guidance.nice.org.uk/PH11).
Royal College of Midwives		Appendix B	'The need of specific groups, in particular …. men and women' Presumably this means the different needs of men and women. This reads strangely, as men and women being a specific group.	Thank you for your comment. The wording of this section has been amended in line with your comments.
Royal College of Nursing		General	With a membership of over 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK	Thank you.

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			parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. The RCN welcomes proposals to develop this guidance. It is timely.	
Royal College of Nursing		2 a)	Pre-diabetes is a term that is currently used. We must retain IGT and IFG as separate disease conditions. As IGT and IFG may spontaneously resolve, the implication is that pre-diabetes will inevitably resolve into diabetes. Therefore, it may not be the most 'accurate' term to use. Predisposition to diabetes may be more suitable; likewise 'at risk of diabetes' (AROD) may be more appropriate.	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.
Royal College of Nursing		2 a)	As above, IGT/IFG may not go onto full blown diabetes so pre-diabetes is not an accurate term. However, in engaging people in their risk for developing diabetes, it is useful, so depends on the audience the term is being used for.	Thank you for your comments.

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Royal College of Nursing		2 d)	Schools/health visitors are important groups to include in prevention. Although the scope for this guidance does not include children, much of the lifestyle issues are embedded in how children are brought up and indeed, the seeds of "pre-diabetes" are sown in childhood, particularly as obesity is an increasing problem with children. When involving children, you involve whole families too.	Thank you for your comments. The guidance will not be extended to children and young people under 18 years of age. Considering adulthood to start at age18 is in line with the NICE guidance on the prevention and management of obesity. The type of interventions that may be effective, and the type of professionals for whom the guidance would apply, would be quite different for children and adults. Extending the scope to under 18s would mean that we could jeopardise giving vulnerable groups in adulthood or childhood sufficient consideration. However, we agree that this is a key area for consideration, particularly due to the rise in cases of type 2 diabetes and prevalence of obesity in children and young people. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/sugges

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				tatopic/suggest_a_topic.jsp
Royal College of Nursing		3 b)	Waist measurement for men: figure quoted is incorrect (should be 94cm) Correct measurement is used later in the document)	Thank you for highlighting this error; the scope has been amended.
Royal College of Nursing		3 c)	This states: 'Improved insulin resistance can prevent pre-diabetes'. It is improved insulin sensitivity that can prevent development of diabetes, not improved insulin resistance. Insulin resistance is the problem! - Should this be saying 'decreased insulin resistance or increased insulin sensitivity?	Thank you for your comments. The scope has been amended in line with your comments.
Royal College of Nursing		3 c)	Again, not sure of the term - pre-diabetes in this context, would prefer 'impaired blood glucose' although being advised that one is pre diabetic might be a greater motivator to change lifestyle practices!	Thank you for your comments. For consistency we have used the term 'pre-diabetes throughout the scope, however, this section of the scope has been amended for clarity.
Royal College of Nursing		4.1.1	It is good to see the focus includes women with gestational diabetes.	Thank you for your comment.

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Royal College of Nursing		4.1.1	Include people with risk factors associated with type 2 diabetes? Dyslipidaemia, hypertension? Also people on diabetogenic drugs- e.g. long term steroid users	Aspects of the guidance may apply to people with pre-existing conditions such as dyslipidaemia and hypertension, or taking diabetogenic drugs. However, specific issues on the prevention of type 2 diabetes for people with pre-existing conditions are outside the remit of this work due to the possible role of drug treatments in pre-disposing individuals to type 2 diabetes and/or particular clinical or other issues which may either increase their risk or influence the nature of intervention.
Royal College of Nursing		4.1.2	It is not clear why neither pregnant women nor those with elevated blood glucose due to e.g. steroids are excluded. These patient groups are the ones that are high risk of diabetes in the future and we would have thought that they should be included in this guidance as every opportunity should be taken to identify the at risk people and to begin the process of lifestyle changes required.	Please see previous comments above
Royal College of Nursing		4.1.2	Children should be included - by the time overweight children become adults, the damage is done and the lifestyle is ingrained	Please see previous comments.
Royal College of Nursing		4.2	These seem to be appropriate and challenging.	Thank you.
Royal College of Nursing		4.2	Key questions – What barriers are there politically/nationally/environmentally (e.g.	Thank you raising this important issue. The guidance is aimed at considering

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			planning permission for fast food outlets, playgrounds closing in schools, availability of safe areas to walk in) that stop people reducing their risk of developing diabetes?	wide ranging population approaches (local and national) to reduce risk of pre-diabetes, and so where relevant evidence is available on the issues you raise we would be able to take it into account in developing the guidance. In addition, some of the issues you raise are dealt with by other NICE guidance. We anticipate that the guidance will cross refer to other NICE guidance, including: • Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. • Physical activity and the environment • Promoting physical activity in the workplace • Prevention of cardiovascular disease. (due to be published in March 2010) Please note we intend to review qualitative studies looking at the views of people from high risk groups to assess barriers and facilitators to interventions aiming to prevent pre-diabetes.

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Royal College of Nursing		4.2	Expected outcomes - Increase in "healthy environments" to make reducing risk of getting diabetes easier, making healthy choices easy.	Please refer to previous response above. We anticipate that the guidance will cross refer to other NICE guidance, including physical activity and the environment.
Royal College of Paediatrics and Child Health		General	It is unclear the need to involve under-18s in this guidance. It is possible that the second guidance (which will look at progression from pre-diabetes to diabetes) might be of greater relevance to children. This guideline excludes that aspect, which is the biggest issue. The management of insulin resistance and the prevention of progression to Type 2 Diabetes could be argued to include children. If the principle is that children should be included in every guideline which might be of any relevance then they should be included. The key point here is the initial DH referral: Appendix A Referral from the Department of Health The Department of Health asked NICE to: 'produce public health programme guidance for the health service on the prevention of type 2 diabetes mellitus among high-risk groups'. The decision to go for over 18 year olds belongs to NICE which is displeasing. At a NICE consultation meeting last year, attended also by the RCPCH clinical effectiveness team, a very strong case was put forward for always considering children/adolescents in every NICE process, which was subsequently agreed.	Thank you for your comments. The guidance will not be extended to children and young people under 18 years of age. Considering adulthood to start at age18 is in line with the NICE guidance on the prevention and management of obesity. The type of interventions that may be effective, and the type of professionals for whom the guidance would apply, would be quite different for children and adults. Extending the scope to under 18s would mean that we could jeopardise giving vulnerable groups in adulthood or childhood sufficient consideration. However, we agree that this is a key area for consideration, particularly due to the rise in cases of type 2 diabetes and prevalence of obesity in children and young people. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a

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				suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Royal College of Paediatrics and Child Health		General	Children with Type 2 diabetes are seen by clinicians. A recent survey in England revealed nearly 400 children with Type 2 diabetes Although the numbers are not huge it is expected to increase if the obesity problems continues along US lines. Children as young as 11 are presenting with Type 2 diabetes. It is becoming evident that referrals are increasing for girls with insulin resistance, obesity and PCOS, so prevention in under 18s must be included in the scope Children with Type 2 Diabetes are known to have an accelerated course of complications, especially relating to kidney function. There are some well-defined "at risk" groups in the Asian population and those with strong family history who in particular should be targeted for prevention. Previously, NICE did not produce guidance on the management of Type 2 diabetes in young people, and this was a lost opportunity.	See previous response.
Royal College of Physicians		general	The College supports the need for guidance and the overall direction of the scoping proposal	Thank you.

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Royal College of Physicians		general	There is no mention about alcohol consumption or cigarette smoking as additional medical risk factors associated with impaired glucose tolerance (IGT). We advise that these two aspects need to be included in section 4.2 as part of question 6 when considering overall health benefits from intervention.	Thank you for your comment. We will consider all appropriate evidence relevant to our scope and review questions, if there is evidence concerning alcohol consumption and smoking in relation to our outcomes of interest (e.g. BMI, weight management etc) then it will be taken into account when developing the guidance. However, please note that existing NICE guidance deals specifically with alcohol consumption and smoking (see: http://www.nice.org.uk/Guidance/PHG/Published).
Royal College of Physicians		general	There needs to be acknowledgement and evaluation of the influence of the media on people's perceptions of IGT and beliefs also about alternative therapies (particularly relevant to some ethnic groups).	Thank you for highlighting this issue.

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Royal College of Physicians		general	Terminology is important here. Pre-diabetes seems to imply inevitable progression to diabetes which is not necessarily the case, even in the absence of intervention. The terms impaired fasting glucose (IFG) and impaired glucose tolerance are clearly defined diagnostic terms but require an oral glucose tolerance test for diagnosis and individuals frequently change categories on repeat testing. The ADA, EASD and WHO are currently considering whether to move away from glucose tolerance testing and to use HbA1c as a diagnostic test. For this reason a more general term i.e. 'impaired glucose regulation' may be preferred as this may be more future proof, encompasses both IGT and IFG and does not imply inevitable progression to diabetes.	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.
Royal College of Physicians		2b	Even overweight individuals (BMI 25-30) are at increased risk for diabetes (2-10 fold compared to a BMI of 22). The mean BMI at diagnosis is about 29. More than 50% of at risk individuals will be missed if only those with obesity are included. The high waist circumference cut-offs will capture some of these individuals, but not all and an important public health message will be missed if overweight individuals are not included.	Thank you for your comments. We have decided to extend the groups at risk to overweight individuals (25 to 30 kg/m^2).
Royal College of Physicians		2d	We are uncertain who/what is a public health nutritionist. There needs to be some mention in this section about recommendations that are culturally and socially applicable and sensitive.	Thank you for your comments. The British Nutrition Foundation website provides the following information:

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				"Public Health Nutrition is the application of the science of nutrition for the benefit of the population as a whole, or sub-sections of the population. It encompasses promotion of good health through nutrition and the primary prevention of diet-related illness in the population. Although an important facet of public health nutrition is establishing the relationships between nutrition and health or disease risk at a research level, equally important is nutrition-related health promotion. This includes the type of work conducted by many of the nutritionists working in the food industry and related trade associations, in government, health promotion, and by dietitians working in the community. In December 1997, the Nutrition Society launched a scheme to register individuals qualified in public health nutrition. Registration usually requires a degree in human nutrition plus a minimum of three

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				years relevant post-graduate experience in public health nutrition. Individuals achieving registration are known as Registered Public Health Nutritionists (RPHNutr)."
South Asian Health Foundation		General	There is much debate regarding the use of the word pre-diabetes and some research and diabetes organisations do not recognise this label. The terminology has also changed since the NHS Health checks have come in which mentions the term non-diabetic hyperglycaemia. There is also a new classification about to come out from WHO, ADA and IDF. The strongest evidence base is for the prevention of type 2 diabetes in high risk individuals (mainly people with IGT) and there is no research evidence base to prevent pre-diabetes - this process would be consistent with prevention of obesity and the Obesity Guidelines would be more appropriate for prevention of prediabetes.	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative. A broad range of evidence types will be considered. Where direct evidence on

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				risk of pre-diabetes is lacking we may, for example, look for evidence outside the diabetes arena and commission expert testimony. This guidance is aimed at considering wide ranging population approaches to reducing pre-diabetes risk rather than a consideration of how to reduce individual risk. The focus of this guidance would be on how to tailor general population advice, for example, on dietary habits, for groups considered to be at high risk of developing pre- diabetes. We anticipate that the guidance will cross refer to other NICE guidance, for example: • Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. • Physical activity and the environment • Promoting physical activity in the workplace
Sustrans		General	Thank you for the opportunity to comment on the scope for this guidance.	Thank you.

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PREVENTION OF TYPE 2 DIABETES: PREVENTING PRE-DIABETES

Draft Scope Consultation – Stakeholder Response Table

From 20 May to 18 June 2009

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Sustrans		2a	We prefer the term pre-diabetes.	Thank you for your comments. We have decided to use the term "pre-diabetes" in the final scope – principally for readability. However we have added additional text to more clearly define what we mean by this term. We acknowledge that there is a lack of consensus on the use of this term and we will consider carefully, with the advice of the Programme Development Group and stakeholders, the best terms for different users of the final guidance. For information, among the organisations who considered this not to be the most appropriate term to use, there was no consensus on the best alternative.
Sustrans		General	We welcome the references in the draft scope to the importance of physical activity levels in maintaining a healthy weight and so in influencing the risk of Type 2 Diabetes and protecting against it.	Thank you for your comments.

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Sustrans	 Creating the environment for activ  Creating the environment for activ	General	We would ask you more explicitly to address the importance of environmental factors in influencing the behaviour of individuals, and in particular their levels of physical activity. The environment is all too often overlooked or undervalued, but we believe it to be of primary importance. I have appended the pdf of "Creating the environment for active travel" (Sustrans 2007) which, although it is not specifically focused on Type 2 Diabetes, illustrates the issue.	Thank you for providing this information.
Sustrans		General	As you review evidence relating to physical activity, we have confidence that you will spread the net to include all forms of "lifestyle" physical activity, and take care to avoid undue concentration on sport and active recreation.	Thank you for your comments. Please be assured that we will include all forms of physical activity, not just exercise or sport.
Sustrans		General	We urge you to consider including evidence relating to intermediate outcomes – such as increases in levels of walking and cycling – where it may not be possible to find studies of the final impact of both environmental and motivational interventions in this field on levels of Type 2 Diabetes.	Thank you for your comments. The PDG may consider the intermediate outcomes you suggest depending on the evidence available.

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Sustrans		General	We urge you to consider including children as an at risk group to be covered in this guidance. Children are a target for policy approaches such as "Healthy Weight Healthy Lives" – and we believe rightly so.	Thank you for your comments. The guidance will not be extended to children and young people under 18 years of age. Considering adulthood to start at age18 is in line with the NICE guidance on the prevention and management of obesity. The type of interventions that may be effective, and the type of professionals for whom the guidance would apply, would be quite different for children and adults. Extending the scope to under 18s would mean that we could jeopardise giving vulnerable groups in adulthood or childhood sufficient consideration. However, we agree that this is a key area for consideration, particularly due to the rise in cases of type 2 diabetes and prevalence of obesity in children and young people. If you feel that this is an area worthy of specific guidance, we would encourage you to submit a suggestion for NICE to develop guidance on this topic: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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