# Resource impact summary report

Resource impact
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## Introduction

Recommendations that represent a change to current practice cover:

- (Offer recommendation) Initial modified-release metformin and SGLT-2 inhibitor treatment for people with type 2 diabetes and:
  - no relevant comorbidity
  - heart failure (with any ejection fraction, unless specified)
  - atherosclerotic cardiovascular disease (ASCVD)
  - early onset type 2 diabetes
  - obesity
  - chronic kidney disease.

- (Offer recommendation) Initial subcutaneous semaglutide (up to 1 mg once a week) treatment for people with type 2 diabetes and:
  - atherosclerotic cardiovascular disease.

- (Consider recommendation) Initial GLP-1 receptor agonist or tirzepatide treatment for people with:
  - early onset type 2 diabetes.

- (Consider recommendation) Further treatment with GLP-1 receptor agonist or tirzepatide are needed to reach their individualised glycaemic targets in people living with:
  - Obesity.

A resource impact template has been developed and published alongside this report.

The key areas of impact are:

- an increase in the cost of treatments in primary care
- a reduction in heart failure hospitalisations
- a reduction in strokes
- a reduction in angina events
- a reduction in myocardial infarctions
- a reduction in established kidney disease
- an increase in GP appointments (initiation of GLP-1 receptor agonist or tirzepatide)
- an increase in pharmacy time (SGLT-2 inhibitor and GLP-1 receptor agonist or tirzepatide)
- a reduction in GP appointments (switching to modified-release metformin)
- a reduction in mortality
- a reduction in insulin use.

# Resource impact (cash and capacity items)

Table 1 highlights for every additional 10,000 people being treated, the increase in treatment costs and the savings from a reduction in events over a 3-year period for the 4 groups below:

- SGLT-2 inhibitors for patients with type 2 diabetes
- Semaglutide (subcutaneous) for patients with type 2 diabetes and ASCVD
- GLP-1 receptor agonist or tirzepatide for patients with early onset type 2 diabetes
- GLP-1 receptor agonist or tirzepatide for patients with type 2 diabetes and obesity.

Table 1 shows the costs and savings for these 4 groups. These costs and savings are over a short period of time (3 years). In clinical practice, people are likely to remain on these medicines (where clinically appropriate) for many years and further events avoided are likely to be realised over this period. Based on committee experience people with early onset type 2 diabetes have a very high lifetime risk of cardiovascular and renal complications, and of dying from them, and are more likely to be living with obesity. Early intensive treatment can provide benefits by preventing these future negative outcomes. The resource impact template also models changes in events avoided over a 10-year period.

**Table 1a Cost and savings for the 4 groups**

| Category | SGLT-2: based on market shares for treatments remaining the same | GLP-1 for ASCVD: based on increase in use of subcutaneous semaglutide only | GLP-1 for early onset (consider recommendation): based on market shares for treatments remaining the same but no increase in tirzepatide (see note) | GLP-1 for obesity when further medicine is required (consider recommendation): based on market shares for treatments remaining the same but no increase in tirzepatide (see note) |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Eligible population for England | 2,524,185 | 719,791 | 108,817 | 273,054 |
| Current number of people having treatment | 1,388,302 | 100,771 | 27,204 | 54,611 |
| Additional number of people treated | 10,000 | 10,000 | 10,000 | 10,000 |
| Additional treatment cost over 3-year period - £m | £3.4 | £28.6 | £28.4 | £28.3 |
| Savings from reduction in events - over 3-year period - £m | -£5.6 | -£6.6 | -£0.2 | -£0.8 |
| **Net financial impact: over 3-year period (£m)** | **-£2.2** | **£22** | **£28.2** | **£27.5** |
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Note: The table does not include any impact on primary care appointments; however, these can be modelled in the template.

**Table 1b Change in events avoided for the 4 groups**

| Category | SGLT-2 - based on market shares for treatments remaining the same | GLP-1 for ASCVD - based on increase in use of subcutaneous semaglutide only | GLP-1 for early onset (consider recommendation) - based on market shares for treatments remaining the same but no increase in tirzepatide (see note) | GLP-1 for obesity when further medicine is required (consider recommendation) - based on market shares for treatments remaining the same but no increase in tirzepatide (see note) |
|---|---|---|---|---|
| Cardiovascular mortality | -187 | -58 | -11 | -24 |
| Heart failure hospital admissions | -178 | 26 | 0 | -5 |
| Myocardial infarctions | -111 | -199 | -17 | -34 |
| Strokes | -21 | -240 | -6 | -31 |
| Progression of established kidney disease | -39 | -4 | 0 | 0 |
| Angina events | -1 | -2 | 6 | 11 |

Note: The table does not include any impact on primary care appointments; however, these can be modelled in the template.

The treatment costs are based on the profile of market shares in the future practice remaining the same as current practice except for the ASCVD group for GLP1 receptor agonist or tirzepatide as the increase is based on subcutaneous semaglutide only. The current practice costs for SGLT-2 inhibitors assumes that in current practice, people have generic dapagliflozin. The cost of treatment may reduce if the price of dapagliflozin generics reduces further or there is a market share shift from comparators to generic dapagliflozin.

The resource impact summary looks at the benefits and costs over a 3-year period for the number people expected to be treated over the 3 years. The health economics underpinning the guidance provided the benefits associated (events avoided) with the use of an SGLT-2 inhibitor and GLP-1 receptor agonist over this time period, and the cost of the drugs is also reported over the same period. There is an additional tab within the template that shows the benefits over a 10-year period.

The change in events avoided for SGLT-2 inhibitors is based on the health economic modelling which compared people treated with SGLT-2 inhibitors and metformin to being treated with metformin alone. For GLP-1 receptor agonists, the comparison was made between people treated with GLP-1 receptor agonists, SGLT-2 inhibitors and metformin compared with being treated with SGLT-2 inhibitors and metformin.

The event rates and cost of the event is based on the economic model. Tirzepatide was not included in the economic model; therefore, no events avoided have been included for tirzepatide in the calculations. This is likely to result in an underestimate of the total benefits if there is an increase in the use of tirzepatide in future practice.

The template has inputted percentages for current and future market share for metformin, SGLT-2 inhibitor, GLP-1 receptor agonists and tirzepatide treatments for all population groups under consideration. Uptake in tirzepatide has grown over the last 12 months but we are unable to ascertain the actual increase for the type 2 diabetes population. Users are advised to adjust these to reflect local practice.

The 'Unit costs' worksheet should be reviewed to ensure costs used represent local cost profiles. This should include confidential prices for tirzepatide and any generic products.

The template assumes people initiating GLP-1 receptor agonists or tirzepatide will require two 20-minute appointments with a band 6 nurse; users can amend the number and time of appointments on the capacity tab in the resource impact template. Users can also amend the nursing or pharmacy time to reflect any additional requirements for prescribing SGLT-2, or GLP-1s or tirzepatide.

There may be a reduction in insulin use because of people having GLP-1 receptor agonists earlier in the treatment pathway. Clinical expert opinion shows a variation in the expected reduction in insulin use because of patients receiving GLP-1 receptor agonists.

Users should take into account there may be some overlap between the subgroups when considering uptake for GLP-1 receptor agonists or tirzepatide.

The resource impact template also includes a worksheet showing the 3-year and 10-year impact of events alongside each other.

Please refer to the rationale and impact section in the guideline, which explains why the committee made the recommendations and how they might affect practice.

# Population covered

Table 2 shows the number of adults eligible for metformin and SGLT-2 inhibitors in England. The prevalence of diabetes is based on Department of Health and Social Care Fingertips data. There is a tab within the template that shows the prevalence of diabetes by integrated care board if users wish to use these instead. The proportion of people with type 2 diabetes is based on Diabetes UK's statistics, and the proportion of people receiving pharmacological treatment is based on the Clinical Practice Research Datalink December 2023 dataset.

**Table 2 Eligible population for metformin and SGLT-2 inhibitors in England**

| Details | Percentage (%) | Number of people |
|---|---|---|
| Adult population | n/a | 47,106,459 |
| Prevalence of diabetes | 8.31 | 3,915,086 |

| | | |
|---|---|---|
| Proportion with type 2 diabetes | 90.00 | 3,523,577 |
| People receiving pharmacological treatment | 71.64 | 2,524,185 |

Table 3 shows the number of adults with type 2 diabetes and ASCVD and eligible for subcutaneous semaglutide in England. The proportion of people with ASCVD and the proportion of people receiving pharmacological treatment is based on the Clinical Practice Research Datalink December 2023 dataset.

**Table 3 Eligible population for subcutaneous semaglutide (ASCVD) in England**

| Details | Percentage (%) | Number of people |
|---|---|---|
| Adult population | n/a | 47,106,459 |
| Prevalence of diabetes | 8.31 | 3,915,086 |
| Proportion with type 2 diabetes | 90.00 | 3,523,577 |
| People with ASCVD | 28.01 | 987,029 |
| People with ASCVD receiving pharmacological treatment | 72.93 | 719,791 |

Table 4 shows the number of adults with early onset type 2 diabetes who are eligible for GLP-1 receptor agonists or tirzepatide in England. The proportion of people with early onset diabetes is based on the young people with type 2 diabetes report 2023/24 from NHS Digital, and the proportion of people receiving pharmacological treatment is based on the Clinical Practice Research Datalink December 2023 dataset.

**Table 4 Eligible population for GLP-1 receptor agonists or tirzepatide (early onset type 2 diabetes) in England**

| Details | Percentage (%) | Number of people |
|---|---|---|
| Adult population | n/a | 47,106,459 |
| Prevalence of diabetes | 8.31 | 3,915,086 |
| Proportion with type 2 diabetes | 90.00 | 3,523,577 |
| People with early onset diabetes | 4.52 | 159,368 |
| People with early onset diabetes receiving pharmacological treatment | 68.28 | 108,817 |

Table 5 shows the number of adults with type 2 diabetes and obesity eligible for GLP-1 receptor agonists or tirzepatide in England. The proportion of people with obesity is based on the Scottish Diabetes Survey 2014 report, and the proportion of people receiving pharmacological treatment is based on the Clinical Practice Research Datalink December 2023 dataset. The proportion of people with obesity receiving pharmacological treatment without ASCVD or early onset and those needing further medicine to reach individualised glycaemic targets, are based on clinical expert opinion.

**Table 5 Eligible population for GLP-1 receptor agonists or tirzepatide (obesity) in England**

| Details | Percentage (%) | Number of people |
|---|---|---|
| Adult population | n/a | 47,106,459 |
| Prevalence of diabetes | 8.31 | 3,915,086 |
| Proportion with type 2 diabetes | 90.00 | 3,523,577 |
| People with obesity | 55.5 | 1,955,585 |

| | | |
|---|---|---|
| People with obesity receiving pharmacological treatment | 72.8 | 1,423,666 |
| Less people with Obesity receiving pharmacological treatment without ASCVD (60% of ASCVD group) | 60.00 | -431,875 |
| Less people with Obesity receiving pharmacological treatment without Early onset (75% of early onset group) | 75.00 | -81,613 |
| Proportion needing further medicine to reach individualised glycaemic targets | 30.00 | 273,054 |

# Key information

**Table 6 Key information**

| | |
|---|---|
| Speciality | Endocrinology and diabetes |
| Disease area | Type 2 diabetes |
| Programme budgeting category | 04A – Diabetes |
| Commissioner(s) | ICBs |
| Provider(s) | Primary care, community health care and secondary care – acute |

# About this resource impact summary report

This resource impact summary report accompanies NICE's guideline on type 2 diabetes in adults: management and should be read with it.