# The draft NICE type 2 diabetes guidance: Does it deliver?

In issue 3 of the journal, Pam Brown very kindly welcomed me as Joint Editor-in-Chief of *Diabetes & Primary Care*. For those of you who do not know me, when I embarked on my career in nursing, I moved from the West Country to Leeds to do a 4-year nursing degree. Nursing degrees have been mandatory for full NMC registration for many years now, but in the mid-Eighties there were only a handful of courses!

At the time, during ward placements, I remember colleagues expressing doubts around the need for a more academic route into a role that was focused on practical skills. I still recall one senior nurse saying, "Those BSc Nurses – all they are good for is talking to patients!" It makes me smile now – of course the practical skills are important and I do think we got there in the end, but it's also important to understand the evidence base (to know why we do what we do). And as for the talking to patients, well, 30 years on I'd say that this is probably the most important part of my job!

I became a Practice Nurse in 1994 and can honestly say it is my dream job although, of course, there have been challenges along the way. It can be a rather lonely role given that you tend to work in relative isolation in a room on your own: very different from the ward scenario where you are surrounded by a team of colleagues. There is huge scope within general practice to work autonomously and to maximum capability – every day is a school day – and there is always something new to learn, which keeps things interesting.

The breadth and complexity of diabetes management is what appealed to me and why I developed a particular interest. I joined the PCDS Committee in 2010 and became Vice Chair in 2016. The majority of diabetes care is now delivered within primary care, much of this by practice nurses, and I hope my involvement with the PCDS has enabled me to promote and support the valuable contribution that all members of the primary healthcare team make to diabetes care by sharing knowledge, skills and expertise.

After 25 years in one practice, a year ago I took up a new post as a Specialist Diabetes Nurse Practitioner within another practice. I now focus wholly on the clinical management of those with diabetes, and this position involves teaching and mentorship of medical and nursing colleagues and trainees. But enough about me – on to my first editorial for the journal!

## New draft NICE type 2 diabetes guidance

At the top of my list of discussion points is the long-awaited update to the NICE guideline on the management of type 2 diabetes in adults. In 2019, we heard that NICE would update NG28, which was welcome news indeed, given that since its publication in 2015 many new blood glucose-lowering agents have been launched and the evidence base, particularly for the cardiovascular and renal protective benefits of some agents, has grown.

The draft for consultation appeared in September 2021 and interested parties ("stakeholders") were invited to comment on the new and updated recommendations proposed, with a deadline for comments of 14 October 2021. A group of us on the committee have responded officially on behalf of the PCDS, but here are a few of my personal thoughts.

The focus is very much on providing education and dietary advice, managing blood glucose levels, managing cardiovascular risk, and identifying and managing long-term complications. Unsurprisingly, one of the most contentious elements is that section on managing blood glucose levels.

It is important to remember that this is a guideline, and NICE itself points out that: *"Clinical guidelines are recommendations on the appropriate treatment and care of people with specific conditions that are based on the best available evidence. They are designed to help*

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*healthcare professionals in their work, but do not replace their knowledge and skills."*

Guidelines provide a framework upon which to base our practice, but they are not absolutes and we must retain the right to use our own clinical judgement. However, the reality in practice is that most prescribing formularies adhere rigidly to the recommendations from NICE, allowing little scope for lateral thinking.

In this journal in June 2014, I published a commentary titled Therapy guidelines for managing type 2 diabetes: A help or a hindrance?, and I think much of what I said then still applies. In this new draft, great emphasis is placed on personalised, patient-centred care, and we are encouraged to fully involve the person with diabetes in treatment decisions. So, what really matters to the person with diabetes? We have to ask them to understand this, and it will vary from person to person (that's what makes us individuals!). That said, in my experience, when it comes to diabetes medications, the things people tend to be concerned about are frequency of dosing; the likely side effects and how these can be managed; and the risks. Most of the people I see wish to avoid medications that are associated with hypoglycaemia or potential weight gain.

The draft guideline begins with a section on individualised care; however, in the proposed algorithm for choosing medicines, I see little opportunity to put this into practice.

There is one big change from 2015, which concerns the place of the SGLT2 inhibitor class. Rather like the American Diabetes Association/European Association for the Study of Diabetes (ADA/EASD) Consensus Report, at the outset we are encouraged to assess cardiovascular risk and kidney function (in addition to $HbA_{1c}$). Based on the person's cardiovascular risk assessment:

- If the person has congestive heart failure or established atherosclerotic cardiovascular disease, offer an SGLT2 inhibitor in addition to metformin.
- If they are at high risk of developing cardiovascular disease, consider an SGLT2 inhibitor in addition to metformin.

SGLT2 inhibitors may also be used as the first-line drug treatment in adults with type 2 diabetes (as above) where metformin is contraindicated or not tolerated.

Otherwise, the algorithm remains largely the same, with a DPP-4 inhibitor, pioglitazone, a sulfonylurea or an SGLT2 inhibitor as options after metformin. I guess one point to bear in mind is that the majority of people we see (with the exception of those at a younger age) will have a QRISK2 score of 10% or more, thus allowing earlier/preferential consideration of an SGLT2 inhibitor.

What surprised me most was that GLP-1 RAs remain a fourth-line option only, given that these are agents with significant glucose-lowering efficacy that are not associated with hypoglycaemia, and which have once-weekly dosing options, potential weight loss effects and, for many, cardiovascular and possibly renal benefits. This is very much at odds with the ADA/EASD guidance, in which the GLP-1 RA class appears as a second-line option.

In practice, if we follow the new guidance from NICE, this means metformin would remain the first-line therapy choice for glucose lowering (unless contraindicated), but alongside an SGLT2 inhibitor as dual therapy at the outset (if there is a cardiovascular risk of >10%). The next step would be to add another oral agent (I suspect DPP-4 inhibitors would be the preferred choice for many), and only where this failed to achieve target $HbA_{1c}$ might we consider a GLP-1 RA.

NICE clearly states that GLP-1 mimetic therapy should not be offered solely for cardiovascular risk reduction, and the starting and stopping criteria remain unchanged; that is, a BMI over 35 $kg/m^2$ unless you can otherwise justify it, and only continue therapy beyond 6 months if the person achieves at least an 11 mmol/mol $HbA_{1c}$ reduction **and** a 3% weight loss from baseline. This bears no resemblance to the ADA/EASD algorithm many us have been using for several years.

The NICE algorithm tells us to assess kidney function. For people with chronic kidney disease (CKD), who are likely to represent up to 30% of those we see with diabetes, we are redirected to the recently updated NICE CKD guidance (NG203). Within the latter document you'll find more on the place of SGLT2 inhibitors, but be aware that this section is already being updated

to reflect changes to the licensed indications for various agents within the class (due to publish at the end of November 2021).

Signposting to other NICE guidelines seems to be a feature of the new type 2 guidance, another example being hypertension, for which we are redirected to NG136 (updated in 2019). Here we are advised that there is insufficient evidence to support lower blood pressure targets for people with diabetes – other than in those with coexisting CKD. For people with diabetes and CKD, it's back to the NG203 guideline! All in all, for those hoping for a simpler life, I don't think this draft delivers!

One of the challenges with diabetes is that there are so many facets to it, and inevitably there will be opinion from a broad spectrum of specialists, as is reflected in relevant guidelines and consensus statements (including those from the ESC, KDIGO and ADA/EASD). However, there is a lack of consistency across the guidelines, which can lead to further confusion. Blood pressure targets are a case in point, and with this is mind we have set about creating a new feature for the journal: the *Need to Know* series. This will essentially be a series of rapid-reference cribsheets – a quick memory jogger – with key information which you can pin onto your notice board.

Our first will tackle blood pressure targets; we hope it will prove useful and time-saving. If you need to go into just a little more detail, take a look at our How to series, which provides readers with quick, printable guides to clinical procedures and aspects of diabetes care that are covered in the clinic setting.

## In this issue

There is lots to read in issue 5, although hopefully the gradual release of articles as "early view" every fortnight is helping to space out your reading. The virtual EASD Annual Meeting took place between 27 September and 1 October, with highlights including new data from the DAPA-CKD study of dapagliflozin, the ReTUNE study showing that weight loss can lead to type 2 diabetes remission even in those of normal weight, and how to move diabetes care forward during and after the COVID-19 pandemic. In the first part of her comprehensive review, Pam Brown discusses these findings and more.

The emotional impact of living with diabetes should not be underestimated, nor indeed should the impact of the diagnosis itself, which for many is very difficult to come to terms with. We have a key role to play in delivering the news of a diabetes diagnosis in primary care, and Jen Bateman provides great insight into how we can do this better. It's difficult to predict a person's reaction – some have described it as the "push" they needed to make lifestyle changes, while others are racked with disbelief, fear, anger and even guilt. Jen offers some really helpful tips to guide our discussions and to find the right balance of conveying the seriousness of the condition whilst also giving hope and reasons for optimism.

Our second how-to article is an update of my guide to assessing fitness to drive, which incorporates new rules from the DVLA on flash glucose monitoring, as well as setting out all the responsibilities of both the healthcare professional and the person with diabetes.

David Morris continues his series of interactive case studies, taking a look at fatty liver disease in type 2 diabetes. Elsewhere, Peter Hammond takes questions from primary care on maximising the benefits of diabetes technology, with topics including the upskilling of healthcare professionals, analysing glucose data, driving laws, improving access and the role of primary care. We also have some interesting discussion from Rebecca Thomas and colleagues on how the conversation within the diabetes online community changed over the course of the pandemic, and a Q&A with an expert PCDS panel on the impact of ethnic and cultural inequalities on diabetes care.

In our *Diabetes Distilled* section, Kevin Fernando and Pam Brown review the latest papers of interest, covering empagliflozin in heart failure with preserved ejection fraction; finerenone in chronic kidney disease; a new consensus on the definition of type 2 diabetes remission; and an in-depth discussion of blood pressure targets in response to new data.

On that note, I hope that, despite the challenges we have faced since March 2020, your interest and enthusiasm for delivering the best possible diabetes care remains strong. If you have any ideas of topics you'd like to see in the journal, please do let us know. ■

**Upcoming PCDS events**

**17th National Conference**
**The road ahead: Revitalising diabetes care and addressing inequality in the post-pandemic world**
18–19th November 2021
Click here to learn more

**PCDS Question Time**
**The COVID-19 backlog and beyond**
4th November 2021
Click here to learn more

**14th All-Ireland Conference**
**Broadening perspectives: Advancing the care of people with diabetes**
27th November 2021
Click here to learn more