

# New guidance is welcome, but challenges will require some creative thinking

We start the New Year with many exciting issues to consider. The American Diabetes Association's [Standards of Care in Diabetes – 2023](#) have recently been released. This comprehensive “live” document is a real go-to for all aspects of diabetes care. It is refreshing to see the change of focus for type 2 diabetes, with real emphasis on weight loss, which now has the same importance as glycaemic control.

Highlighting support for weight loss, and an acknowledgement that no single dietary intervention is supreme, allows us to work alongside people to find the best intervention for them. I particularly applaud the recognition of food insecurity as an issue we all must recognise and appreciate. I am sure we have all been aware of an increasing concern regarding food insecurity since the beginning of the pandemic. The recommendation from the ADA is that we should all explore the risk of food insecurity in households, and consider them at risk of they agree with either of the two statements below.

Within the past 12 months:

*“We worried whether our food would run out before we got money to buy more.”*

or

*“The food we bought just didn't last, and we didn't have money to get more.”*

Working alongside our dietetic colleagues then becomes essential to assess the overall nutritional status for these individuals and to work collaboratively in the creation of an individualised meal plan.

There is also an emphasis in the standards on both non-alcoholic fatty liver disease (NAFLD) and non-alcoholic steatohepatitis (NASH), with an update to section on its [diagnosis and management](#). People with diabetes have an

increased risk of poorer outcomes and earlier progression to fibrosis and cirrhosis within the NAFLD population. I am sure we are going to see a greater focus on, the recognition of and education regarding liver disease during 2023. I recommend to you a very [useful factsheet](#) by Dr Pam Brown covering this and other key updates to the *ADA Standards*, and published in *Diabetes & Primary Care*.

We also await the release of the update to NICE guideline CG181 on *Cardiovascular disease: risk assessment and reduction, including lipid modification*. The [draft guidance](#) recommends the use of statins for the primary prevention of cardiovascular disease (CVD) in the general population, in those with a 10-year risk score of <10%. It advises the use of the QRISK3 tool to ascertain CVD risk for those with type 2 diabetes aged 25–84 years.

This, in addition to the use of statins in type 1 diabetes for those who have had diabetes for ≥10 years, will see a greater number of women of childbearing age fall into the category for statin recommendation or consideration. NICE does make very clear recommendations for the stopping of statins if there is a risk of pregnancy or if a pregnancy is being planned. However, the overall impact of this updated guidance will inevitably see a far greater proportion of our diabetes population supported with statins, once it is finalised later this year.

In addition to these updates, we eagerly await finalisation of the NICE guidance on *Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes*. [Draft guidance](#) was published in January, and submission of comments has recently closed.

Whilst the recommendations of broadening the use of such systems represents a very exciting and considerable step forward for type 1 diabetes, and a further, hugely welcome, stride in the use



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***“The use of technicians within diabetes teams has been shown to save many hours of time, freeing healthcare professionals to offer support and advice in diabetes management.”***

of technology in the management of diabetes, all teams will have to assess the impact of fulfilling the recommendations, once they are published. Specialist care teams will now have to plan for the increase in workload that will inevitably result. This coincides with an increased use of both intermittently scanned CGM (isCGM, commonly known as “flash”) and real-time CGM (rtCGM) in the type 2 population.

The resulting capacity issues for teams across the whole of healthcare provision, be that primary, intermediate or secondary care, are not to be underestimated. At a very rough estimate, there are just over 700 people within my area (Somerset) who would fit the criteria for a hybrid-closed loop system.

Creative use of personnel, such as technicians

at band 3 or 4, will become more widespread. There are already some imaginative initiatives across the country where technicians are being employed within diabetes teams to help directly with the onboarding of technology, to support the uploading or sharing of CGM data, or to assist with the initial challenges faced when using new, unfamiliar technology, be that CGM or a pump. Their use has been shown to save many hours of time, freeing healthcare professionals to offer support and advice in diabetes management. I feel certain that the use of technicians within our team composition will increase rapidly.

As Heraclitus the Greek philosopher said, “The only constant in life is change”, and never could this be truer than now. ■