2015: The year of change in diabetes

The year 2015 promises to be one of significant change for all of us involved in diabetes, with four new NICE diabetes guidelines (NICE, 2015a), diabetes prevention finally on the agenda, and an election looming with potential impact on the NHS.

Here at *Diabetes & Primary Care*, we too face change. I am excited and privileged to take over as Editor-in-Chief from Colin Kenny, who will continue as Editor-in-Chief of *Diabetes Distilled*, the Primary Care Diabetes Society's e-newsletter. I bring to the Journal more than 30 years' experience as a "jobbing" GP in South Wales, helping deliver diabetes care in a busy city practice, and more than 20 years' involvement in medical education. I am very fortunate to be supported by the new Associate Editor-in-Chief, Jane Diggle, a practice nurse in West Yorkshire. Jane is a skilled educator and communicator with extensive expertise in diabetes, and she will be well known to many of you who have attended her masterclasses at national and regional conferences.

We wish the previous Associate Editor-in-Chief, Gwen Hall, and Colin Kenny health and happiness as they move on to new projects, including semi-retirement. We will continue to involve them in writing for the Journal and providing their wise counsel to help us maintain the quality of our content and our practical approach.

New education modules

In this issue, we launch the new cycle of education modules, beginning with "Diabetes diagnosis and presentation" (starting on page 36). Each issue of the Journal will include a module, with these building into an up-to-date educational resource. If you are not already signed up on Diabetes on the Net, our online portal, please register to answer the CPD questions, receive your certificate and log your achievements. You will also have access to other resources, including previous issues of the Journal.

NICE

The "Diabetes in pregnancy" NICE guideline is scheduled for publication in February 2015 and we will explore this in the next edition. The NICE guidelines on "Type 1 diabetes in adults" and "Diabetes in children (type 1 and 2)" are out for consultation until March 2015 and due for publication in August. Much has changed since the 2004 type 1 diabetes guideline, including tighter control, new technologies such as insulin pumps and continuous glucose monitoring, and therapeutic advances encompassing new insulins, new protocols for diabetic ketoacidosis, and transplantation, all of which are highlighted in the drafts.

The draft guideline on type 2 diabetes (NICE, 2015b), due for publication in August 2015, is also out for consultation. There is much to applaud in this draft, including a strong focus on patient-centred care, and involving people with diabetes in setting individualised glycaemic targets and making fully informed decisions regarding therapy choices. This will be time-consuming to implement, but should improve safety and help people feel involved in their treatment, possibly aiding adherence.

However, the drug therapy section (see algorithms on pages 13 and 14 of the full draft guideline) gives serious cause for concern. The algorithms are complex and include drugs which many in primary care are not confident prescribing, and therefore may compromise patient safety. The recommendation to use repaglinide or pioglitazone as first-line therapy in those intolerant of standard-release metformin, rather than switching to modified-release metformin, is surprising.

Repaglinide, a short-acting insulin secretagogue administered at meal-times as a postprandial glucose regulator, was launched in the UK in 1998, shortly after troglitazone. It failed to capture a significant share of the market despite education highlighting the impact of postprandial glucose on glycaemic control, and the flexibility offered to those with erratic meal-times. Repaglinide is only licensed for monotherapy or combination with metformin (electronic Medicines Compendium [eMC], 2012), and so the treatment algorithms propose

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that if repaglinide fails to achieve or maintain control, then at "first intensification" repaglinide should be stopped and step-wise introduction of two additional therapies undertaken. This will be confusing for many people with diabetes, and may damage clinicians' credibility. Interestingly, in those tolerant of metformin, repaglinide is not proposed at "first intensification".

The full version of the draft includes "evidence to recommendations" tables, which help explain how Guideline Development Group decisions were reached. Inclusion of repaglinide and pioglitazone as first-line options in those intolerant of metformin, and inclusion of pioglitazone at "first intensification", are based on network meta-analyses demonstrating that sulphonylureas and repaglinide were most effective in improving glycaemia at 3 and 6 months, and repaglinide best at 12 months (albeit based on small numbers). Pioglitazone demonstrated greatest glucose lowering at 24 months. Since pioglitazone is contraindicated in those with previous or current heart failure, previous or current bladder cancer, or uninvestigated macroscopic haematuria, and because an increased risk of fracture must be considered (eMC, 2014), it means that many people will receive the other two first-line options, sulphonylureas or dipeptidyl peptidase-4 inhibitors. The positioning of sodium–glucose cotransporter 2 inhibitors as options at "first intensification" rather than first line is no surprise. Rather than including them in the algorithms, NICE is advising prescribers to consult the relevant technology appraisals for guidance on their use.

At the time of writing, the Primary Care Diabetes Society is in the process of surveying members to inform the Society's feedback on the draft guideline to NICE.

Updated NICE guideline on obesity

NICE Clinical Guideline 189, *Obesity: identification, assessment and management of overweight and obesity in children, young people and adults* (NICE, 2014b), was published in November 2014. This is a partial update of Clinical Guideline 43 and most of the guidance remains unchanged. The updated sections cover questions posed to the review group on very-low-calorie diets (VLCDs) and bariatric surgery.

NICE makes the recommendation that VLCDs (800 kcal/day or less) should only be used "as part of a multicomponent weight management strategy for people who are obese and have a clinically-assessed need to rapidly lose weight." Those delivering the diets are encouraged to ensure they are nutritionally complete, they are followed for a maximum of 12 weeks and that, before commencement, clinicians assess the individual for eating disorders or other mental health problems, discuss the risks and benefits and ensure the person understands that VLCDs are not a long-term weight management strategy and that weight regain may occur. People on VLCDs should be taught how to reintroduce food after a liquid diet and have access to a long-term multicomponent strategy for weight maintenance. These safeguards are already provided by those offering some VLCDs, but if we are recommending or referring for a VLCD, we need to ensure guidance is followed.

The guideline highlights the cost-effectiveness of bariatric surgery and encourages us to offer rapid referral for Tier 3 weight management services and assessment for surgery for people with a BMI of at least 35 kg/m^2 and type 2 diabetes duration of 10 years or less. Although this may seem like extreme management, when we consider the complications of diabetes that may be prevented or lessened, the risks associated with obesity (see, for instance, the piece on page 16 of this edition), and surgery's cost-effectiveness, it's easier to understand. In *Box 1,* Nigel Campbell reflects on why he would like to be able to commission bariatric surgery for appropriate people with type 2 diabetes in Northern Ireland. As a first step, we may need to identify how we access local Tier 3 services.

We all need help to manage obesity effectively and NICE Public Health Guideline 53, *Managing overweight and obesity in adults – lifestyle weight management services* (NICE, 2014a), published in May 2014, opens up new possibilities in these resource-restricted times. We are encouraged to utilise the behaviour change expertise, regular reviews and peer support provided not only by NHS weight management services but also by commercial organisations, such as WeightWatchers® (Jebb et al, 2011; Jolly et al,

Box 1. Views of a commissioning GP on bariatric surgery.

Nigel Campbell
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I do feel frustration at not having a funded bariatric service available in Northern Ireland. From the arguments and evidence that I've seen, it makes good economic sense to have one. Of course, there are many intricacies beyond just having the service in place and funded. We would need a robust means of deciding who is put forward for surgery. Where do we place the bar? The new NICE obesity guideline is helpful in providing recommendations in this area.

I personally have three registered patients who had bariatric surgery several years ago under a pilot run by the Department of Health, Social Services and Public Safety in Northern Ireland. Two of these had diabetes and both remain off glycaemic medication at this point. Once the pilot is reported on, if the results are broadly positive, I hope that access to a service will become available for more people in Northern Ireland. We currently have trained surgeons but no funds with which to commission this. The challenging financial environment at present does not make progress any easier.

2011), Slimming World (Madigan et al, 2014) and Counterweight® (McCombie et al, 2012; Morrison et al, 2013), which are demonstrated to be effective in helping people lose weight. For those of you who remain sceptical, I urge you to read the papers and, if convinced, to lobby for free access for your patients.

SB Communications Group is launching the *British Journal of Obesity* this year as the official journal of the National Obesity Forum, and this will provide practical guidance on obesity management.

Diabetes prevention programmes planned in England

Although the intensive lifestyle programmes used in large prevention studies (Tuomilehto et al, 2001; Diabetes Prevention Program Research Group, 2002) were labour intensive, there are now translational studies (Brokaw et al, 2014; Dunkley et al, 2014) that are identifying more cost-effective ways to achieve the weight reduction, dietary changes and increased physical activity associated with the 58% reduction in type 2 diabetes incidence in those at highest risk of developing the condition. NICE Public Health Guidance 38, *Preventing type 2 diabetes: risk identification and intervention for individuals at high risk* (NICE, 2012), chaired by PCDS Committee research lead Kamlesh Khunti, recommended that evidence-based, quality-assured, intensive lifestyle programmes be developed and offered to those at highest risk of diabetes across the UK. More than 2 years later, NHS England's "Forward View into action" planning document (NHS England, 2014) announced that a national type 2 diabetes prevention programme will finally be developed jointly with Diabetes UK and Public Health England, and implemented from 2016. Let's hope this triggers action across the devolved nations.

Election 2015

Health and the NHS are key campaigning topics for the 2015 general election. All parties have published their manifestos and propose to transform the health and well-being of the population. To keep abreast of what is being promised, consult the King's Fund "Health and social care election tracker" (http://election.kingsfund.org.uk). It remains to be seen how these promises will translate into funding for healthcare, including diabetes, later in the year.

New Year's resolutions

At this time of year we all think about what we can do better. My "diabetes resolutions" are to:

- Ask about hypoglycaemia more often (aided by Jane Diggle's article starting on page 44).
- Discuss diet and recommend the NHS Choices "Live Well" resources (available at http://www.nhs.uk/livewell/Pages/Livewellhub.aspx) and Patient.co.uk's Mediterranean diet advice sheet (http://medical.cdn.patient.co.uk/pdf/9222.pdf) – aided by Jen Nash's article on emotional eating (starting on page 21) and Emma Smith's article on a local primary care dietetic service (starting on page 31).
- Review people with diabetes in our care homes (see Roger Gadsby's comment discussing the recent audit on page 14).
- Ensure our medical students are enthused and knowledgeable about diabetes (see Azhar Farooqi's comment on page 12), including sharing with them Shelpa Parmar and Helen Noakes' work on developing a local insulin prescribing support aid (see their article starting on page 27).

I look forward to sharing a busy 2015 with you, to enlisting your help to make *Diabetes & Primary Care* even more useful to you, and to hearing your views and publishing your innovations and achievements, as we all work to improve diabetes care across the UK. ■

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