# NICE enough for nurses?

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After a few delays the long-awaited NICE clinical guideline for the management of type 2 diabetes was published at the end of May this year (National Collaborating Centre for Chronic Conditions [NCCCC], 2008a). This guideline brought together and updated the previously published guidelines on management of blood glucose and blood pressure and lipids, and the guidelines on screening, prevention and early management of retinopathy and renal disease in type 2 diabetes.

The NICE quick reference guide (NCCCC, 2008b) recommends that "treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care... if the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care."

I would like to discuss the issues around the new guidance that will have an impact on nurses working in diabetes care.

## Patient education

NICE advises that :structured education is an integral part of diabetes care, and patients and carers should be informed of this. Offer it, preferably through a group education programme, to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Offer an alternative of equal standard to people unable or unwilling to participate in group education" (NCCCC, 2008b). Education for people with type 2 diabetes is predominately provided within the primary care setting, but – as the NICE technology appraisal on patient education in diabetes (NICE, 2005) reported – while education is usually offered at diagnosis it varies in length of time, content and delivery. At the time of the appraisal only 55% of PCTs were offering structured education (DoH and Diabetes UK, 2005). The Department of Health in conjunction with Diabetes UK developed key criteria by which 'structured education' should be matched (DoH and Diabetes UK, 2005). They should:

- Have a structured, written curriculum.
- Have trained educators.
- Be quality assured.
- Be audited.

Primary care organisations and local diabetes teams were charged with working towards these criteria, and aiming to ensure that all people with diabetes had access to local education programmes meeting these standards by January 2006 (DoH and Diabetes UK, 2005) – however, there has not yet been an audit to see how many PCTs achieved this aim. Enfield PCT, London, implemented the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) programme in mid-2005.

## Dietary advice

The NICE quick reference guide (National Collaborating Centre for Chronic Conditions, 2008b) suggests that we should "provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition", it is interesting that it doesn't qualify this individual as a dietitian. Perhaps this is because dietitians are in short supply nationwide or PCTs do not seem to place much importance on this group of healthcare professionals, despite dietetic advice being an integral part of diabetes care. Ever since I took up the post of Nurse Consultant at Enfield PCT, I have struggled to increase the amount of dietetic input into the diabetes service without success, even though our waiting list for dietetic support is longer than for seeing a DSN. Within primary care it is usually the practice nurse who provides the initial dietary advice – however, in many cases the practice nurse will not usually be someone "with specific expertise and competencies in nutrition".

## Setting a target $HbA_{1c}$

I am constantly amused by the range of 'ideal' $HbA_{1c}$ targets that are aimed for in diabetes care around the world – and, while I appreciate that this is always in the context of 'individualised targets', we should be able to come to some agreement what the global target for $HbA_{1c}$ should be. NICE suggests that, when setting a target $HbA_{1c}$, healthcare professionals should:

- Involve the person in decisions about their $HbA_{1c}$ target level, which may be above that of 6.5% set for people with type 2 diabetes in general.
- Encourage the person to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life.
- Offer therapy (lifestyle and medication) to help achieve and maintain the $HbA_{1c}$ target level.
- Inform a person with a higher $HbA_{1c}$ that any reduction in $HbA_{1c}$ towards the agreed target is advantageous to future health.
- Avoid pursuing highly intensive $HbA_{1c}$

management to levels of less than 6.5%.

This new guidance seems more sensible than previously, and takes into account the recent information released from the ACCORD study in which it was found that intensive glycaemic control in people at high cardiovascular risk caused an increase in risk of major cardiovascular risk and mortality (ACCORD Study Group, 2008).

## Self-monitoring of glucose levels

With all the debate surrounding the value of using blood glucose monitoring in type 2 diabetes, it is interesting that the new NICE guidance suggests "offering self-monitoring of plasma glucose to a person newly diagnosed with type 2 diabetes only as an integral part of his or her self-management education" (NCCCC, 2008a).

In most of the existing guidelines available around the UK, including the consensus statement on self-monitoring of blood glucose (SMBG) (Owens et al, 2005) and our consensus in Enfield PCT (Enfield PCT, 2008), it is suggested that self-monitoring of blood glucose is not necessary at diagnosis unless there are identified problems with glycaemic levels. I suspect that a few PCT pharmaceutical advisors around the UK will be nervous regarding the impact of this section of the guidance, as it may lead to an increase in the prescribing of test strips despite the current (financially-driven) aim to reduce the amount of test strip usage among people with type 2 diabetes. All healthcare professionals providing training in SMBG should be aware that NICE recommends the use of meters that measure plasma glucose levels as opposed to whole blood glucose levels. In Enfield PCT we recently standardised the meters available in our PCT to a range that specifically measures plasma glucose – however, those who are currently using a meter that measures whole blood glucose can continue to do so.

## Initiating insulin therapy

NICE states that "when starting insulin therapy, use a structured education programme employing active insulin dose titration that encompasses:

- Structured education.
- Continuing telephone support.
- Frequent self-monitoring [of plasma glucose].
- Dose titration to target.
- Dietary understanding.
- Management of hypoglycaemia.
- Management of acute changes in plasma glucose control.
- Support from an appropriately trained and experienced healthcare professional" (NCCCC, 2008a).

Unfortunately, it is my experience that people with type 2 diabetes commencing insulin therapy in the primary care setting are not receiving appropriate choice, education and support. We are now developing an Insulin Initiation Care Pathway, in collaboration with our two hospital teams, in order to ensure that when insulin therapy is commenced, regardless of location, the individual concerned will receive the same quality of choice, education and support.

## Blood pressure and lipid management

I was dismayed to see that, in the blood pressure management section of the guideline, the target for blood pressure without complications has remained at 140/80mmHg for people without complications; for those with renal, eye or cerebrovascular damage it has been reduced to 130/80mmHg from 135/75mmHg. This is, surprisingly, not in keeping with the NICE guidance on management of hypertension in adults (NCCCC, 2006) which suggests a target of 130/85mmHg for people with diabetes or renal disease. On discussion with the acute care physicians at the two hospitals within the Enfield PCT area, we have made the decision not to change the guidance within our local diabetes care pathway to reflect that of the new NICE guidance but to retain our previous targets – 130/80mmHg for people without complications and 120/70mmHg for those with complications. We have also adopted the suggested targets for lipid management of <4.0mmol/L for total cholesterol and <2.0mmol/L for LDL-cholesterol for people with type 2 diabetes, as the majority of these people will be at high risk.

## Conclusion

In my opinion, these new and uninspiring guidelines are not really nice enough for nurses. They do not tell us anything we didn't already know, and the dietetic advice is lamentable. In support of the new guidance, I like the flow charts as they are easy to follow and allow for individual patient needs. Our local guidelines were updated in April 2008 (Enfield PCT, 2008) using the draft NICE guidance and remain, in the most part, aligned to the final document. Further guidance is expected from NICE relating to the management of chronic kidney disease in September 2008 and on newer agents for blood glucose control in type 2 diabetes in February 2009. Time will tell if these will be nice for nurses or not! ■

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