

National Institute for Health and Care Excellence

Type 1 Diabetes Update

Stakeholder Comments – Draft Guideline

NOTE:

NICE is unable to accept comments from non-registered organisations or individuals. If you wish your comments to be considered but are not a registered stakeholder, please register via the [NICE website](#) or contact the [registered stakeholder organisation](#) that most closely represents your interests and pass your comments to them.

Please fill in both the ‘stakeholder organisation’ and ‘name of commentator’ fields below in order for your comments to be considered.

Stakeholder Organisation:		DIABETES UK		
Name of commentator:				
Order number <i>(For internal use only)</i>	Document	Section Number	Page Number	Comments
	Indicate if you are referring to the Full version NICE version or the Appendices	Indicate number or ‘general’ if your comment relates to the whole document	Indicate number or ‘general’ if your comment relates to the whole document	<p>Please insert each new comment in a new row.</p> <p>Please do not paste other tables into this table, as your comments could get lost – type directly into this table.</p>
Example	Full	3.4.6	45	Our comments are as follows
Proformas that are not correctly submitted as detailed in the example above may be returned to you.				
1	NICE	General	General	We suggest NICE include the need for regular dental check- ups and appropriate dental care in this guideline. This is clearly explained in the draft guideline for children and young people with diabetes. This recommendation should be replicated for adults.
2	NICE	General	General	We suggest NICE include a warning in the guideline for people with Type 1 diabetes about the dangers of substance abuse (may destabilise glucose control).
3	NICE	General	General	Throughout the guidance there is a lack of consideration of the particular difficulties faced by people with very long duration of Type 1 diabetes in setting targets and particularly in avoiding hypoglycaemia.
4	NICE	1.3.1	18	We feel this recommendation is too prescriptive. Some people with Type 1 diabetes will benefit from a course such as DAFNE earlier than 6 months and some later than 1 year. Education should be offered at the point appropriate to the individual. People with diabetes want flexible approaches to learning that fit with their lives and this should be made clearer in the guideline. We would recommend that individuals should be offered appropriate learning and education at the point of diagnosis, some structured education within 12 months and DAFNE or equivalent within 24 months.

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				We are also concerned that the guidance does not adequately cover people with existing Type 1 who have not been offered structured education previously. Education should be available whenever people need it, and not only in the two years following diagnosis.
5	NICE	1.4.3	20	We are concerned that this point could be misconstrued to mean that people with Type 1 diabetes should not follow a low GI diet. A healthy diet usually contains some low GI foods and there are instances, particularly around exercise, where low GI foods can be beneficial. We recommend that this point is made clearer and include the need for a healthy balanced diet.
6	NICE	1.6.6 1.6.7 1.6.8	24	We would like to see much greater prominence to the recommendation of agreeing an individualized target HbA1c especially in relation to the potential of problematic hypoglycaemia. We are concerned about the safety of lowering the target HbA1c level to the level recommended as this risks increasing episodes of hypoglycaemia for people with Type 1 diabetes. This lower target could also be seen as unachievable and so dis-incentivise them to achieve it. We also question how many people could achieve the lower target. For these reasons we believe that a target range for HbA1c is stated, and it should be made very clear that any target should be set in consultation with the person with Type 1 diabetes taking into account factors such as daily activities, aspirations, complications, co-morbidities, occupation and history of hypoglycaemia.
7		1.6.12 1.6.13	25	We support the recommendation for frequent blood glucose monitoring as this will help overcome the difficulty that some people with Type 1 are facing in obtaining sufficient blood glucose testing strips.
8	NICE	1.6.15 1.6.16	26 26	We are concerned that the different targets for different times of the day are confusing for people with diabetes and may dis-incentivise them. We would suggest a clear target for blood glucose level at bedtime is stated. Depending on the time of the bedtime test relating to the evening meal, the draft recommendations suggest that a level as low as 5 would be acceptable before bed which we do not feel is appropriate as it may cause night time hypoglycaemia. We note that DAFNE recommend a target of 6.5-8mmols/l and suggest that target should be considered.
9	NICE	1.6.16	26	The guideline should clearly state how long after a meal people with Type 1 diabetes should expect to achieve these blood glucose levels, eg 1 or 2 hours.
10	NICE	1.6.21	26	Regarding CGMS, we would ask for some clarity over the phrasing "...any of the following that persist..." We feel that it should be made clearer that CGMS should be considered if a person with diabetes has one or more of the following list.
11	NICE	1.6.21	26	We would like to see "frequent hypos with or without awareness" added to the list.
12	NICE	1.6.23	27	We would ask for some clarity on what constitutes a centre of expertise in the use of CGMS. We feel that it is important for this standard to be clearly set out by NICE to ensure that people with diabetes are not subject to poor quality care and all people with Type 1 diabetes should have access to a centre of excellence.
13	NICE	1.7.4	27	We recommend that the need to personalize treatment is given greater priority.

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				<p>While we support the recommendation for basal bolus regimens, there are certain people with diabetes who may need less intensive regimens at certain times. The recommendation of detemir twice daily as a first choice for basal insulin therapy is too prescriptive and does not allow for individual patient choice and clinical judgement.</p> <p>While we appreciate that the draft guidance goes on to consider other insulin regimens, this is not given sufficient priority and does not allow the clinician to personalize treatment to the needs of the individual.</p>
14	NICE	1.7.14	29	We would like to make the point that the BMI cut off might need to be ethnic specific.
15	NICE	1.8.3	30	We are concerned that the recommendations on needle length are not sufficient to allow a choice of needle length that will ensure that insulin is delivered into the deep sub-cutaneous tissue. People with diabetes may inject at an inappropriate depth without experiencing pain, local skin reactions and injection site leakages. This can significantly impact on diabetes management.
16	NICE	1.8.4	30	While we accept the principle of minimising cost, we would ask for this recommendation to be removed as it does not allow a clinician to use their own clinical judgement and may encourage the use of poor quality equipment.
17	NICE	1.8.5	30	The guideline should include more detail on the absorption rates of human/anologue insulin. The Forum for Injection Technique recommend that the thigh and buttocks are the preferred site for injecting NPH, and the abdomen for injecting soluble human insulin. However rapid and long acting insulin analogues may be given at any of the injection sites as absorption rates do not seem to be site specific (FIT http://www.trend-uk.org/documents/FIT%20Recommendations%20Page%20view.pdf)
18	NICE	1.9.1	30	We would like to see a recommendation around simultaneous pancreas and kidney transplantation for those people with Type 1 diabetes who need kidney transplantation.
19	NICE	1.10.6	31	<p>While we are aware of the findings of the Compass study that suggests that targeted education can reduce hypos irrespective of CSII and/or CGMS use, we feel this recommendation requires further thought.</p> <p>We are concerned that this recommendation is potentially dangerous to people with Type 1 diabetes. We recognise that this recommendation may be appropriate for highly specialised Type 1 centres, but are concerned that for most diabetes services there is a safety issue. In people who have reduced awareness of hypoglycaemia, a temporary relaxation in blood glucose targets can help ensure safety while measures such as intensive diabetes education are put in place.</p>
20	NICE	1.11.1	34	The word “consider” should be removed from this point as all people with Type 1 diabetes should have some form of ketone measurement to help prevent DKA.
21	NICE	1.11.3	34	While capillary ketone measurement can be helpful there is a concern that if using ketones rather than serum bicarbonate levels to assess recovery from DKA, fluids may be terminated earlier than desirable, especially in people who are dehydrated.
22	NICE	1.13.4	37	We would like clarity over lipid targets for people with Type 1 diabetes as the lipid modification guidelines do

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				not state a target. The recommendation to “aim for a greater than 40% reduction in non-HDL cholesterol” is not helpful for people with Type 1 diabetes and does not give a lower cut off.
23	NICE	1.15.8	41	The need for retinal screening post islet cell or pancreas transplant, even if insulin is no longer required, should be included as retinopathy can still appear or progress.
24	NICE	1.15.21	43	We appreciate that the guidance notes the risk of orthostatic hypotension, but we feel a low cut-off for BP should also be stated. We advise that the Joint British Societies guidance should be followed: “Blood pressure should be maintained at 130/80 mm Hg and consideration of lower values (120/75–80 mm Hg) as a target in younger type 1 diabetes (aged <40 years) with persistent micro albuminuria”. (JBS3 Heart 2014; 100:ii1-ii67).

Please add extra rows as needed.

Please email this form to: T1Dupdate@nice.org.uk

Closing date: 4 March 2015 at 5pm

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